

John Fiske (CA SBN 249256)
BARON & BUDD, P.C.
603 North Coast Highway, Suite G
Solana Beach, CA 92075
Tel.: 858-633-8337
jfiske@baronbudd.com

Margaret E. Long (CA SBN 227176)
TRINITY COUNTY COUNSEL
2240 Court Street
Redding, CA 96001
Tel: 530-691-0800
Fax: 530-691-0700
margaret@plelawfirm.com

(Additional Counsel Listed on Signature Page)

Attorneys for Plaintiffs COUNTY OF TRINITY, a political subdivision of the State of California; THE PEOPLE OF THE STATE OF CALIFORNIA, acting by and through the COUNTY OF TRINITY

**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
REDDING DIVISION**

COUNTY OF TRINITY,
a political subdivision of the
State of California; THE PEOPLE
OF THE STATE OF CALIFORNIA,
acting by and through the COUNTY
OF TRINITY.

Plaintiffs.

VS.

AMERISOURCEBERGEN DRUG CORPORATION; CARDINAL HEALTH, INC.; McKESSON CORPORATION; PURDUE PHARMA L.P.; PURDUE PHARMA, INC.; THE PURDUE FREDERICK COMPANY, INC.; TEVA PHARMACEUTICAL INDUSTRIES, LTD.; TEVA PHARMACEUTICALS USA, INC.; CEPHALON, INC.; JOHNSON & JOHNSON; JANSSEN PHARMACEUTICALS, INC.; ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC. n/k/a JANSSEN PHARMACEUTICALS, INC.; JANSSEN PHARMACEUTICA

Case No.: _____

COMPLAINT FOR DAMAGES AND DEMAND FOR JURY TRIAL

(1) Public Nuisance;
 (2) Violations of Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961 et seq.;
 (3) Violations of 18 U.S.C. § 1962 et seq.;
 (4) Violations of the California False Advertising Act, Cal. Bus. & Prof. Code § 17500 et seq.;
 (5) Negligent Misrepresentation;
 (6) Fraud and Fraudulent Misrepresentation; and
 (7) Unjust Enrichment.

1 INC. n/k/a JANSSEN
2 PHARMACEUTICALS, INC.;
3 NORAMCO, INC.; ENDO HEALTH
4 SOLUTIONS INC.; ENDO
5 PHARMACEUTICALS, INC.;
6 ALLERGAN PLC f/k/a ACTAVIS
7 PLS; WATSON
8 PHARMACEUTICALS, INC. n/k/a
9 ACTAVIS, INC.; WATSON
10 LABORATORIES, INC.; ACTAVIS
11 LLC; ACTAVIS PHARMA, INC. f/k/a
12 WATSON PHARMA, INC.;
MALLINCKRODT PLC;
MALLINCKRODT LLC; INSYS
THERAPEUTICS, INC; CVS
HEALTH CORP.; THE KROGER CO.;
RITE AID OF MARYLAND, INC.;
THRIFTY PAYLESS, INC.;
WALGREENS BOOTS ALLIANCE,
INC.; and WAL-MART, INC..

13 Defendants.

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	PARTIES	2
	A. PLAINTIFFS.	2
	B. DEFENDANTS.	4
	1. Manufacturer Defendants.....	4
	2. Distributor Defendants.....	10
III.	JURISDICTION & VENUE.....	14
IV.	FACTUAL BACKGROUND.....	15
	A. THE OPIOID EPIDEMIC.....	15
	1. The National Opioid Epidemic.....	15
	2. The California Opioid Epidemic.....	19
	3. The Opioid Epidemic in Plaintiffs' Community.....	22
	B. THE MANUFACTURER DEFENDANTS' FALSE, DECEPTIVE, AND UNFAIR MARKETING OF OPIOIDS.....	26
	1. Each Manufacturer Defendant Used Multiple Avenues to Disseminate Their False and Deceptive Statements about Opioids.....	28
	a) Direct Marketing.....	29
	b) Indirect Marketing.	31
	2. The Manufacturer Defendants' Marketing Scheme Misrepresented the Risks and Benefits of Opioids.....	42
	i. The Manufacturer Defendants embarked upon a campaign of false, deceptive, and unfair assurances grossly understating and misstating the dangerous addiction risks of the opioid drugs.	42
	ii. The Manufacturer Defendants embarked upon a campaign of false, deceptive, and unfair assurances grossly overstating the benefits of the opioid drugs.....	53

1	3. The Manufacturer Defendants Targeted Susceptible Prescribers and Vulnerable Patient Populations	60
2	4. Insys Employed Fraudulent, Illegal, and Misleading Marketing Schemes to Promote Subsys.	61
3	5. The Manufacturer Defendants made Materially Deceptive Statements and Concealed Material Facts.	66
4	6. The Manufacturer Defendants Fraudulently Concealed Their Misconduct.....	71
5	C. THE DISTRIBUTOR DEFENDANTS' UNLAWFUL DISTRIBUTION OF OPIOIDS.....	73
6	1. Wholesale Drug Distributors Have a Duty under State and Federal Law to Guard Against, and Report, Unlawful Diversion and to Report and Prevent Suspicious Orders.	74
7	2. The Distributor Defendants Breached Their Duties.	83
8	3. The Distributor Defendants Have Sought to Avoid and Have Misrepresented their Compliance with Their Legal Duties.	86
9	4. The National Retail Pharmacies Were on Notice of and Contributed to Illegal Diversion of Prescription Opioids	93
10	D. THE MANUFACTURER DEFENDANTS' UNLAWFUL FAILURE TO PREVENT DIVERSION AND MONITOR, REPORT, AND PREVENT SUSPICIOUS ORDERS.....	105
11	E. DEFENDANTS' UNLAWFUL CONDUCT AND BREACHES OF LEGAL DUTIES CAUSED THE HARM ALLEGED HEREIN AND SUBSTANTIAL DAMAGES.	111
12	F. STATUTES OF LIMITATIONS ARE TOLLED AND DEFENDANTS ARE ESTOPPED FROM ASSERTING STATUTES OF LIMITATIONS AS DEFENSES.....	114
13	1. Enforcement of a Public Right.....	114
14	2. Continuing Conduct.....	114
15	3. Equitable Estoppel.	114
16	4. Fraudulent Concealment	117
17	V. LEGAL CAUSES OF ACTION	118
18	COUNT I – PUBLIC NUISANCE (Brought by The People Against all Defendants)	118
19	COUNT II – PUBLIC NUISANCE (Brought by The County Against all Defendants)	127
20		
21		
22		
23		
24		
25		
26		
27		
28		

1	COUNT III – RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT 18 U.S.C. § 1961, et seq. (Against Defendants Purdue, Cephalon, Janssen, and Endo).....	133
3	RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT 18 U.S.C. § 1961, et seq.	133
4	(Against Defendants Purdue, Cephalon, Janssen, and Endo)	133
5	A. THE OPIOID MARKETING ENTERPRISE	136
6	1. The RICO Defendants.....	138
7	2. The Front Groups	142
8	3. The KOLs.....	153
9	4. Members of the Opioid Marketing Enterprise Furthered the Common Purpose by Making Misrepresentations.....	168
10	B. CONDUCT OF THE OPIOID MARKETING ENTERPRISE	230
11	C. PATTERN OF RACKETEERING ACTIVITY	234
12	D. DAMAGES.....	241
13	1. Impact of the Opioid Marketing Enterprise.	241
14	2. Relief Sought.	248
15	COUNT IV - RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT.....	251
16	18 U.S.C. 1961, et seq.....	251
17	(Against Defendants Purdue, Cephalon, Endo, Mallinckrodt, Actavis, McKesson, Cardinal, and AmerisourceBergen)	251
18	(The “Opioid Diversion Enterprise”).....	251
19	A. THE OPIOID DIVERSION ENTERPRISE.....	256
20	B. CONDUCT OF THE OPIOID DIVERSION ENTERPRISE.	269
21	C. PATTERN OF RACKETEERING ACTIVITY.....	277
22	1. The RICO Defendants Manufactured, Sold and/or Dealt in Controlled Substances and Their Actions Constitute Crimes Punishable as Felonies.	277
23	2. The RICO Diversion Defendants Engaged in Mail and Wire Fraud.	284
24	D. DAMAGES.....	292
25	1. Impact of the Opioid Diversion Enterprise.	292
26	2. The Relief Sought.	298
27	COUNT V - FALSE ADVERTISING	302

1	_Toc513566355	
2	Violations of California Business and Professions Code section 17500, et seq.	302
3	COUNT VI - NEGLIGENT MISREPRESENTATION	305
4	COUNT VII - FRAUD AND FRAUDULENT MISREPRESENTATION	309
5	COUNT VIII - UNJUST ENRICHMENT	311
6	PUNITIVE DAMAGES	313
7	RELIEF	314
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		

1 Plaintiffs, COUNTY OF TRINITY, and THE PEOPLE OF THE STATE
2 OF CALIFORNIA, acting by and through Trinity County Counsel, (collectively
3 “Plaintiffs”) bring this Complaint against Defendants Purdue Pharma L.P.; Purdue
4 Pharma, Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceutical
5 Industries, LTD.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson &
6 Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals,
7 Inc. n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceutica Inc. n/k/a Janssen
8 Pharmaceuticals, Inc.; Noramco, Inc.; Endo Health Solutions, Inc.; Endo
9 Pharmaceuticals, Inc.; Allergan PLC f/k/a Actavis PLS; Watson Pharmaceuticals,
10 Inc. n/k/a Actavis, Inc.; Watson Laboratories, Inc.; Actavis, LLC; Actavis
11 Pharma, Inc. f/k/a Watson Pharma, Inc.; Mallinckrodt PLC; Mallinckrodt LLC;
12 Insys Therapeutics, Inc., McKesson Corporation; Cardinal Health, Inc.;
13 AmerisourceBergen Drug Corporation, CVS Health Corporation; The Kroger Co.;
14 Rite Aid of Maryland, Inc. d/b/a Rite Aid Mid-Atlantic Customer Support Center,
15 Inc.; Thrifty Payless, Inc.; Walgreens Boots Alliance, Inc. a/k/a Walgreen Co.,
16 and Wal-Mart Inc., f/k/a Wal-Mart Stores, Inc., (collectively “Defendants”) and
17 allege as follows:

18 **I. INTRODUCTION**

19 1. Plaintiffs bring this civil action to eliminate the hazard to public
20 health and safety caused by the opioid epidemic, to abate the nuisance caused
21 thereby, and to recoup monies that have been spent and will be spent because of
22 Defendants’ false, deceptive and unfair marketing and/or unlawful diversion of
23 prescription opioids.¹ Such economic damages were foreseeable to Defendants
24 and were sustained because of Defendants’ intentional and/or unlawful actions
25 and omissions.

26
27
28 ¹ As used herein, the term “opioid” refers to the entire family of opiate drugs
including natural, synthetic and semi-synthetic opiates.

2. Opioid analgesics are widely diverted and improperly used, and the widespread abuse of opioids has resulted in a national epidemic of opioid overdose deaths and addictions.²

3. The opioid epidemic is “directly related to the increasingly widespread misuse of powerful opioid pain medications.”³

4. Plaintiffs bring this suit against the manufacturers of prescription opioids. The manufacturers aggressively pushed highly addictive, dangerous opioids, falsely representing to doctors that patients would only rarely succumb to drug addiction. These pharmaceutical companies aggressively advertised to and persuaded doctors to prescribe highly addictive, dangerous opioids, turning patients into drug addicts for their own corporate profit. Such actions were intentional and/or unlawful.

5. Plaintiffs also bring this suit against the wholesale distributors of these highly addictive drugs. The distributors and manufacturers intentionally and/or unlawfully breached their legal duties under federal and state law to monitor, detect, investigate, refuse and report suspicious orders of prescription opiates.

II. PARTIES

A. PLAINTIFFS.

6. Plaintiffs, THE PEOPLE OF THE STATE OF CALIFORNIA (“The People”), acting by and through Trinity County Counsel Margaret E. Long, and TRINITY COUNTY, CALIFORNIA, (“The County”), are authorized to bring the causes of action brought herein. The County is a body corporate and politic of the

² See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

³ See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*, 374 N. Eng. J. Med. 1480 (2016).

1 State of California. Cal. Gov't Code § 23003. The County is authorized to bring
2 this action. Cal. Gov't Code § 23004(a).

3 7. The County is responsible for the public health, safety and welfare of
4 its citizens.

5 8. The County has declared, *inter alia*, that opioid abuse, addiction,
6 morbidity and mortality have created a serious public health and safety crisis, and
7 is a public nuisance, and that the diversion of legally produced controlled
8 substances into the illicit market causes or contributes to this public nuisance.

9 9. The distribution and diversion of opioids into California (“the
10 State”), and into Trinity County and surrounding areas (collectively, “Plaintiffs’
11 Community”), created the foreseeable opioid crisis and opioid public nuisance for
12 which Plaintiffs here seek relief.

13 10. Plaintiffs directly and foreseeably sustained all economic damages
14 alleged herein. Defendants’ conduct has exacted a financial burden for which the
15 Plaintiffs seek relief. Categories of past and continuing sustained damages
16 include, *inter alia*: (1) costs for providing medical care, additional therapeutic,
17 and prescription drug purchases, and other treatments for patients suffering from
18 opioid-related addiction or disease, including overdoses and deaths; (2) costs for
19 providing treatment, counseling, and rehabilitation services; (3) costs for
20 providing treatment of infants born with opioid-related medical conditions; (4)
21 costs associated with law enforcement and public safety relating to the opioid
22 epidemic; (5) costs associated with providing care for children whose parents
23 suffer from opioid-related disability or incapacitation and (6) costs associated with
24 The County having to repair and remake its infrastructure, property and systems
25 that have been damaged by Defendants’ actions, including, *inter alia*, its property
26 and systems to treat addiction and abuse, to respond to and manage an elevated
27 level of crime, to treat injuries, and to investigate and process deaths in Plaintiffs’
28

1 Community. These damages have been suffered, and continue to be suffered,
2 directly by the Plaintiffs.

3 11. Plaintiffs also seek the means to abate the epidemic created by
4 Defendants' wrongful and/or unlawful conduct.

5 12. The People have standing to bring an action for the opioid epidemic
6 nuisance created by Defendants. Cal. Civ. Proc. Code § 731 ("A civil action may
7 be brought in the name of the people of the State of California to abate a public
8 nuisance, as defined in Section 3480 of the Civil Code, by the . . . county counsel
9 of any county in which the nuisance exists.").

10 13. The County has standing to bring an action for damages incurred to
11 its property by the public nuisance created by Defendants. Cal. Civ. Proc. Code §
12 731 ("An action may be brought by any person whose property is injuriously
13 affected, . . . and by the judgment in that action the nuisance may be enjoined or
14 abated as well as damages recovered therefor.").

15 14. The People have standing to bring this claim for injunctive relief and
16 civil penalties under the California False Advertising Act. Cal. Bus. & Prof. Code
17 §§ 17535, 17536.

18 15. The County has standing to recover damages incurred as a result of
19 Defendants' actions and omissions. Cal. Gov't Code § 23004(a). The County has
20 standing to bring claims under the federal RICO statute, pursuant to 18 U.S.C. §
21 1961(3) ("persons" include entities which can hold legal title to property) and 18
22 U.S.C. § 1964 ("persons" have standing).

23 **B. DEFENDANTS.**

24 **1. Manufacturer Defendants.**

25 16. The Manufacturer Defendants are defined below. At all relevant
26 times, the Manufacturer Defendants have packaged, distributed, supplied, sold,
27 placed into the stream of commerce, labeled, described, marketed, advertised,
28 promoted and purported to warn or purported to inform prescribers and users

1 regarding the benefits and risks associated with the use of the prescription opioid
2 drugs. The Manufacturer Defendants, at all times, have manufactured and sold
3 prescription opioids without fulfilling their legal duty to prevent diversion and
4 report suspicious orders.

5 17. PURDUE PHARMA L.P. is a limited partnership organized under
6 the laws of Delaware. PURDUE PHARMA INC. is a New York corporation with
7 its principal place of business in Stamford, Connecticut, and THE PURDUE
8 FREDERICK COMPANY, INC. is a Delaware corporation with its principal
9 place of business in Stamford, Connecticut (collectively, “Purdue”).

10 18. Purdue manufactures, promotes, sells, and distributes opioids such as
11 OxyContin, MS Contin, Dilaudid/Dilaudid HP, Butrans, Hysingla ER, and
12 Targiniq ER in the United States. OxyContin is Purdue’s best-selling opioid.
13 Since 2009, Purdue’s annual nationwide sales of OxyContin have fluctuated
14 between \$2.47 billion and \$2.99 billion, up four-fold from its 2006 sales of \$800
15 million. OxyContin constitutes roughly 30% of the entire market for analgesic
16 drugs (painkillers).

17 19. CEPHALON, INC. is a Delaware corporation with its principal place
18 of business in Frazer, Pennsylvania. TEVA PHARMACEUTICAL
19 INDUSTRIES, LTD. (“Teva Ltd.”) is an Israeli corporation with its principal
20 place of business in Petah Tikva, Israel. In 2011, Teva Ltd. acquired Cephalon,
21 Inc. TEVA PHARMACEUTICALS USA, INC. (“Teva USA”) is a Delaware
22 corporation and is a wholly owned subsidiary of Teva Ltd. in Pennsylvania. Teva
23 USA acquired Cephalon in October 2011.

24 20. Cephalon, Inc. manufactures, promotes, sells, and distributes opioids
25 such as Actiq and Fentora in the United States. Actiq has been approved by the
26 FDA only for the “management of breakthrough cancer pain in patients 16 years
27 and older with malignancies who are already receiving and who are tolerant to
28

1 around-the-clock opioid therapy for the underlying persistent cancer pain.”⁴
 2 Fentora has been approved by the FDA only for the “management of breakthrough
 3 pain in cancer patients 18 years of age and older who are already receiving and
 4 who are tolerant to around-the-clock opioid therapy for their underlying persistent
 5 cancer pain.”⁵ In 2008, Cephalon pled guilty to a criminal violation of the Federal
 6 Food, Drug and Cosmetic Act for its misleading promotion of Actiq and two other
 7 drugs, and agreed to pay \$425 million.⁶

8 21. Teva Ltd., Teva USA, and Cephalon, Inc. work together closely to
 9 market and sell Cephalon products in the United States. Teva Ltd. conducts all
 10 sales and marketing activities for Cephalon in the United States through Teva
 11 USA and has done so since its October 2011 acquisition of Cephalon. Teva Ltd.
 12 and Teva USA hold out Actiq and Fentora as Teva products to the public. Teva
 13 USA sells all former Cephalon branded products through its “specialty medicines”
 14 division. The FDA-approved prescribing information and medication guide, which
 15 is distributed with Cephalon opioids, discloses that the guide was submitted by
 16 Teva USA, and directs physicians to contact Teva USA to report adverse events.

17 22. All of Cephalon’s promotional websites, including those for Actiq
 18 and Fentora, display Teva Ltd.’s logo.⁷ Teva Ltd.’s financial reports list
 19 Cephalon’s and Teva USA’s sales as its own, and its year-end report for 2012 –
 20 the year immediately following the Cephalon acquisition – attributed a 22%

21
 22 ⁴ *Highlights of Prescribing Information, ACTIQ® (fentanyl citrate) oral*
 23 *transmucosal lozenge, CII* (2009),
https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020747s030lbl.pdf.

24 ⁵ *Highlights of Prescribing Information, FENTORA® (fentanyl citrate) buccal*
 25 *tablet, CII* (2011),
https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021947s015lbl.pdf.

26 ⁶ Press Release, U.S. Dep’t of Justice, Biopharmaceutical Company, Cephalon, to
 27 Pay \$425 Million & Enter Plea to Resolve Allegations of Off-Label Marketing
 28 (Sept. 29, 2008), <https://www.justice.gov/archive/opa/pr/2008/September/08-civ-860.html>.

⁷ E.g., ACTIQ, <http://www.actiq.com/> (displaying logo at bottom-left) (last visited Jan. 16, 2018).

1 increase in its specialty medicine sales to “the inclusion of a full year of
 2 Cephalon’s specialty sales,” including *inter alia* sales of Fentora®.⁸ Through
 3 interrelated operations like these, Teva Ltd. operates in the United States through
 4 its subsidiaries Cephalon and Teva USA. The United States is the largest of Teva
 5 Ltd.’s global markets, representing 53% of its global revenue in 2015, and, were it
 6 not for the existence of Teva USA and Cephalon, Inc., Teva Ltd. would conduct
 7 those companies’ business in the United States itself. Upon information and
 8 belief, Teva Ltd. directs the business practices of Cephalon and Teva USA, and
 9 their profits inure to the benefit of Teva Ltd. as controlling shareholder. Teva
 10 Pharmaceutical Industries, Ltd., Teva Pharmaceuticals USA, Inc., and Cephalon,
 11 Inc. are referred to as “Cephalon.”

12 23. JANSSEN PHARMACEUTICALS, INC. is a Pennsylvania
 13 corporation with its principal place of business in Titusville, New Jersey, and is a
 14 wholly owned subsidiary of JOHNSON & JOHNSON (J&J), a New Jersey
 15 corporation with its principal place of business in New Brunswick, New Jersey.
 16 NORAMCO, INC. (“Noramco”) is a Delaware company headquartered in
 17 Wilmington, Delaware and was a wholly owned subsidiary of J&J until July 2016.
 18 ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., now known as
 19 JANSSEN PHARMACEUTICALS, INC., is a Pennsylvania corporation with its
 20 principal place of business in Titusville, New Jersey. JANSSEN
 21 PHARMACEUTICA INC., now known as JANSSEN PHARMACEUTICALS,
 22 INC., is a Pennsylvania corporation with its principal place of business in
 23 Titusville, New Jersey. J&J is the only company that owns more than 10% of
 24 Janssen Pharmaceuticals’ stock, and corresponds with the FDA regarding
 25 Janssen’s products. Upon information and belief, J&J controls the sale and
 26

27 28 ⁸ Teva Ltd., Annual Report (Form 20-F) 62 (Feb. 12, 2013),
 http://annualreports.com/HostedData/AnnualReportArchive/t/NASDAQ_TEVA_2
 012.pdf.

1 development of Janssen Pharmaceuticals' drugs and Janssen's profits inure to
2 J&J's benefit. Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen
3 Pharmaceuticals, Inc., Janssen Pharmaceutica, Inc., Noramco, and J&J are
4 referred to as "Janssen."

5 24. Janssen manufactures, promotes, sells, and distributes drugs in the
6 United States, including the opioid Duragesic (fentanyl). Before 2009, Duragesic
7 accounted for at least \$1 billion in annual sales. Until January 2015, Janssen
8 developed, marketed, and sold the opioids Nucynta (tapentadol) and Nucynta ER.
9 Together, Nucynta and Nucynta ER accounted for \$172 million in sales in 2014.

10 25. ENDO HEALTH SOLUTIONS INC. is a Delaware corporation with
11 its principal place of business in Malvern, Pennsylvania. ENDO
12 PHARMACEUTICALS INC. is a wholly owned subsidiary of Endo Health
13 Solutions Inc. and is a Delaware corporation with its principal place of business in
14 Malvern, Pennsylvania. Endo Health Solutions Inc. and Endo Pharmaceuticals
15 Inc. are referred to as "Endo."

16 26. Endo develops, markets, and sells prescription drugs, including the
17 opioids Opana/Opana ER, Percodan, Percocet, and Zydome, in the United States.
18 Opioids made up roughly \$403 million of Endo's overall revenues of \$3 billion in
19 2012. Opana ER yielded \$1.15 billion in revenue from 2010 and 2013, and it
20 accounted for 10% of Endo's total revenue in 2012. Endo also manufactures and
21 sells generic opioids such as oxycodone, oxymorphone, hydromorphone, and
22 hydrocodone products in the United States, by itself and through its subsidiary,
23 Qualitest Pharmaceuticals, Inc.

24 27. ALLERGAN PLC is a public limited company incorporated in
25 Ireland with its principal place of business in Dublin, Ireland. ACTAVIS PLC
26 acquired ALLERGAN PLC in March 2015, and the combined company changed
27 its name to ALLERGAN PLC in January 2013. Before that, WATSON
28 PHARMACEUTICALS, INC. acquired ACTAVIS, INC. in October 2012, and

1 the combined company changed its name to Actavis, Inc. as of January 2013 and
 2 then ACTAVIS PLC in October 2013. WATSON LABORATORIES, INC. is a
 3 Nevada corporation with its principal place of business in Corona, California, and
 4 is a wholly-owned subsidiary of ALLERGAN PLC (f/k/a Actavis, Inc., f/k/a
 5 Watson Pharmaceuticals, Inc.). ACTAVIS PHARMA, INC. (f/k/a Actavis, Inc.) is
 6 a Delaware corporation with its principal place of business in New Jersey and was
 7 formerly known as WATSON PHARMA, INC. ACTAVIS LLC is a Delaware
 8 limited liability company with its principal place of business in Parsippany, New
 9 Jersey. Each of these defendants is owned by ALLERGAN PLC, which uses them
 10 to market and sell its drugs in the United States. Upon information and belief,
 11 ALLERGAN PLC exercises control over these marketing and sales efforts and
 12 profits from the sale of Allergan/Actavis products ultimately inure to its benefit.
 13 ALLERGAN PLC, ACTAVIS PLC, ACTAVIS, Inc., Actavis LLC, Actavis
 14 Pharma, Inc., Watson Pharmaceuticals, Inc., Watson Pharma, Inc., and Watson
 15 Laboratories, Inc. are referred to as "Actavis."

16 28. Actavis manufactures, promotes, sells, and distributes opioids,
 17 including the branded drugs Kadian and Norco, a generic version of Kadian, and
 18 generic versions of Duragesic and Opana, in the United States. Actavis acquired
 19 the rights to Kadian from King Pharmaceuticals, Inc. on December 30, 2008, and
 20 began marketing Kadian in 2009.

21 29. MALLINCKRODT, PLC is an Irish public limited company
 22 headquartered in Staines-upon-Thames, United Kingdom, with its U.S.
 23 headquarters in St. Louis, Missouri. MALLINCKRODT, LLC is a limited liability
 24 company organized and existing under the laws of the State of Delaware.
 25 Mallinckrodt, LLC is a wholly owned subsidiary of Mallinckrodt, PLC.
 26 Mallinckrodt, PLC and Mallinckrodt, LLC are referred to as "Mallinckrodt."

27 30. Mallinckrodt manufactures, markets, and sells drugs in the United
 28 States including generic oxycodone, of which it is one of the largest

1 manufacturers. In July 2017 Mallinckrodt agreed to pay \$35 million to settle
2 allegations brought by the Department of Justice that it failed to detect and notify
3 the DEA of suspicious orders of controlled substances.

4 31. INSYS THERAPEUTICS, INC. is a Delaware corporation with its
5 principal place of business in Chandler, Arizona. Insys's principal product and
6 source of revenue is Subsys.

7 32. Insys made thousands of payments to physicians nationwide,
8 including in the State, ostensibly for activities including participating on speakers'
9 bureaus, providing consulting services, assisting in post-marketing safety
10 surveillance and other services, but in fact to deceptively promote and maximize
11 the use of opioids.

12 33. Subsys is a transmucosal immediate-release formulation (TIRF) of
13 fentanyl, contained in a single-dose spray device intended for oral, under the
14 tongue administration. Subsys was approved by the FDA solely for the treatment
15 of breakthrough cancer pain.

16 34. In 2016, Insys made approximately \$330 million in net revenue from
17 Subsys. Insys promotes, sells, and distributes Subsys throughout the United
18 States, the County, and Plaintiffs' Community.

19 35. Insys's founder and owner was recently arrested and charged, along
20 with other Insys executives, with multiple felonies in connection with an alleged
21 conspiracy to bribe practitioners to prescribe Subsys and defraud insurance
22 companies. Other Insys executives and managers were previously indicted.

23 **2. Distributor Defendants.**

24 36. The Distributor Defendants also are defined below. At all relevant
25 times, the Distributor Defendants have distributed, supplied, sold, and placed into
26 the stream of commerce the prescription opioids, without fulfilling the
27 fundamental duty of wholesale drug distributors to detect and warn of diversion of
28 dangerous drugs for non-medical purposes. The Distributor Defendants

1 universally failed to comply with federal and/or state law. The Distributor
2 Defendants are engaged in “wholesale distribution,” as defined under state and
3 federal law. Plaintiffs allege the unlawful conduct by the Distributor Defendants is
4 responsible for the volume of prescription opioids plaguing Plaintiffs’
5 Community.

6 37. McKESSON CORPORATION (“McKesson”) at all relevant times,
7 operated as a licensed distributor in California, licensed by the California State
8 Board of Pharmacy and holding both wholesaler and out of state wholesaler
9 distributor licenses. McKesson is a Delaware corporation. McKesson has its
10 principal place of business located in San Francisco, California. McKesson
11 operates distribution centers in Chino, Fullerton, Sacramento and Visalia,
12 California.

13 38. CARDINAL HEALTH, INC. (“Cardinal”) at all relevant times,
14 operated as a licensed distributor in California, licensed by the California State
15 Board of Pharmacy and holding both wholesaler and out of state wholesaler
16 distributor licenses. Cardinal’s principal office is located in Dublin, Ohio.
17 Cardinal operates a distribution center in Sacramento, California.

18 39. AMERISOURCEBERGEN DRUG CORPORATION
19 (“AmerisourceBergen”) at all relevant times, operated as a licensed distributor in
20 California, licensed by the California State Board of Pharmacy and holding both
21 wholesaler and out of state wholesaler distributor licenses. AmerisourceBergen is
22 a Delaware corporation and its principal place of business is located in
23 Chesterbrook, Pennsylvania.

24 40. Defendant CVS HEALTH CORPORATION is a Delaware
25 corporation with its principal place of business in Rhode Island. CVS Health
26 Corporation conducts business as a licensed wholesale distributor under the
27 following named business entities: CVS Indiana, L.L.C.; CVS Orlando FL
28 Distribution; CVS Pharmacy, Inc.; CVS RX Services, Inc, d/b/a CVS Pharmacy

1 Distribution Center; CVS TN Distribution, LLC ; and CVS VERO FL
2 Distribution, L.L.C (collectively “CVS”). At all times relevant to this Complaint,
3 CVS distributed prescription opioids throughout the United States, including in
4 the State and the County and Plaintiffs’ Community specifically. At all relevant
5 times, this Defendant operated as a licensed distributor in California, licensed by
6 the California State Board of Pharmacy.

7 41. Defendant THE KROGER CO. is an Ohio corporation with
8 headquarters in Cincinnati, OH. Kroger operates 2,268 pharmacies in the United
9 States, including in California. The Kroger Co. conducts business as a licensed
10 wholesale distributor under the following named business entities: Kroger Limited
11 Partnership I and Kroger Limited Partnership II (collectively “Kroger”). At all
12 times relevant to this Complaint, Kroger distributed and dispensed prescription
13 opioids throughout the United States, including in California and Plaintiffs’
14 Community specifically. At all relevant times, this Defendant operated licensed
15 pharmacies in California, licensed by the California State Board of Pharmacy.

16 42. Defendant RITE AID OF MARYLAND, INC., d/b/a Rite Aid Mid-
17 Atlantic Customer Support Center, Inc. is a Maryland corporation with its
18 principal office located in Camp Hill, Pennsylvania and is a subsidiary of Rite Aid
19 Corporation. Defendant THRIFTY PAYLESS, INC. is a California corporation
20 with its principal office in located in Camp Hill, Pennsylvania and is a subsidiary
21 of Rite Aid Corporation. Rite Aid of Maryland, Inc., d/b/a as Rite Aid Mid-
22 Atlantic Customer Support Center, Inc. and Thrifty Payless, Inc. are referred to as
23 “Rite Aid.” At all times relevant to this Complaint, Rite Aid distributed
24 prescription opioids throughout the United States, including in the State, the
25 County and Plaintiffs’ Community specifically. Rite Aid of Maryland, Inc., d/b/a
26 Rite Aid Mid-Atlantic Customer Support Center, Inc. conducts business as a
27 licensed wholesale distributor under the name Rite Aid Mid-Atlantic Customer
28 Support Center and at all relevant times, operated as a licensed distributor in

1 California, licensed by the California State of Pharmacy. Thrifty Payless, Inc.
2 conducts business as a licensed wholesale distributor and at all relevant times,
3 operated as a licensed distributor in California, licensed by the California State of
4 Pharmacy.

5 43. Defendant WALGREENS BOOTS ALLIANCE, INC., also known
6 as Walgreen Co. (“Walgreens”) is a Delaware corporation with its principal place
7 of business in Illinois. Walgreens Boots Alliance Inc. conducts business as a
8 licensed wholesale distributor under the following named business entities:
9 Walgreen Co.; Walgreen Eastern Co., Inc.; Walgreen Arizona Drug Co.
10 (collectively “Walgreens”). At all times relevant to this Complaint, Walgreens
11 distributed prescription opioids throughout the United States, including in the
12 State, the County and Plaintiffs’ Community specifically. At all relevant times,
13 this Defendant operated as a licensed distributor in California, licensed by the
14 California State Board of Pharmacy.

15 44. Defendant WAL-MART INC., formerly known as Wal-Mart Stores,
16 Inc. (“Wal-Mart”), is a Delaware corporation with its principal place of business
17 in Arkansas. At all times relevant to this Complaint, Wal-Mart distributed
18 prescription opioids throughout the United States, including in the State, the
19 County and Plaintiffs’ Community specifically. Wal-Mart Stores, Inc. conducts
20 business as a licensed wholesale distributor under the following named business
21 entities: Wal-Mart Warehouse #28; Wal-Mart Warehouse #6045 aka Wal-Mart
22 Warehouse #45; Wal-Mart Warehouse # 6046 aka Wal-Mart Warehouse #46
23 (“collectively “Wal-Mart”). At all relevant times, this Defendant operated as a
24 licensed distributor in California, licensed by the California State Board of
25 Pharmacy.

26 45. Collectively, Defendants CVS, Kroger, Rite Aid, Walgreens, Wal-
27 Mart are referred to as “National Retail Pharmacies.” Cardinal, McKesson,
28

1 AmerisourceBergen, and the National Retail Pharmacies are collectively referred
2 to as the “Distributor Defendants.”

3 46. Defendants include the above referenced entities as well as their
4 predecessors, successors, affiliates, subsidiaries, partnerships and divisions to the
5 extent that they are engaged in the manufacture, promotion, distribution, sale
6 and/or dispensing of opioids.

III. JURISDICTION & VENUE

8 47. This Court has subject matter jurisdiction under 28 U.S.C. § 1331
9 based upon the federal claims asserted under the Racketeer Influenced and
10 Corrupt Organizations Act, 18 U.S.C. § 1961, *et seq.* (“RICO”). This Court has
11 supplemental jurisdiction over Plaintiffs’ state law claims pursuant to 28 U.S.C. §
12 1367 because those claims are so related to Plaintiffs’ federal claims that they
13 form part of the same case or controversy.

14 48. This Court has personal jurisdiction over Defendants because they
15 conduct business in the State, purposefully direct or directed their actions toward
16 the State, some or all consented to be sued in the State by registering an agent for
17 service of process, they consensually submitted to the jurisdiction of the State
18 when obtaining a manufacturer or distributor license, and because they have the
19 requisite minimum contacts with the State necessary to constitutionally permit the
20 Court to exercise jurisdiction.

21 49. This Court also has personal jurisdiction over all of the defendants
22 under 18 U.S.C. § 1965(b). This Court may exercise nation-wide jurisdiction over
23 the named Defendants where the “ends of justice” require national service and
24 Plaintiffs demonstrate national contacts. Here, the interests of justice require that
25 Plaintiffs be allowed to bring all members of the nationwide RICO enterprise
26 before the court in a single trial. *See, e.g., Iron Workers Local Union No. 17*
27 *Insurance Fund v. Philip Morris Inc.*, 23 F. Supp. 2d 796, 803 (N.D. Ohio 1998)
28 (citing *LaSalle National Bank v. Arroyo Office Plaza, Ltd.*, 1988 WL 23824, *2

1 (N.D. Ill. Mar 10, 1988); *Butcher's Union Local No. 498 v. SDC Invest., Inc.*, 788
2 F.2d 535, 539 (9th Cir. 1986)).

3 50. Venue is proper in this District pursuant to 28 U.S.C. § 1391 and 18
4 U.S.C. §1965 because a substantial part of the events or omissions giving rise to
5 the claim occurred in this District and each Defendant transacted affairs and
6 conducted activity that gave rise to the claim of relief in this District. 28 U.S.C. §
7 1391(b); 18 U.S.C. §1965(a).

8 **IV. FACTUAL BACKGROUND**

9 **A. THE OPIOID EPIDEMIC.**

10 **1. The National Opioid Epidemic.**

11 51. The past two decades have been characterized by increasing abuse
12 and diversion of prescription drugs, including opioid medications, in the United
13 States.⁹

14 52. Prescription opioids have become widely prescribed. By 2010,
15 enough prescription opioids were sold to medicate every adult in the United States
16 with a dose of 5 milligrams of hydrocodone every 4 hours for 1 month.¹⁰

17 53. By 2011, the U.S. Department of Health and Human Resources,
18 Centers for Disease Control and Prevention, declared prescription painkiller
19 overdoses at epidemic levels. The News Release noted:

20 a. The death toll from overdoses of prescription painkillers has more
21 than tripled in the past decade.
22 b. More than 40 people die every day from overdoses involving narcotic
23 pain relievers like hydrocodone (Vicodin), methadone, oxycodone
(OxyContin), and oxymorphone (Opana).
24 c. Overdoses involving prescription painkillers are at epidemic levels
25 and now kill more Americans than heroin and cocaine combined.

26 ⁹ See Richard C. Dart et al., Trends in Opioid Analgesic Abuse and Mortality in the
27 United States, 372 N. Eng. J. Med. 241 (2015).

28 ¹⁰ Katherine M. Keyes et al., Understanding the Rural-Urban Differences in
Nonmedical Prescription Opioid Use and Abuse in the United States, 104 Am. J.
Pub. Health e52 (2014).

- 1 d. The increased use of prescription painkillers for nonmedical reasons,
2 along with growing sales, has contributed to a large number of
3 overdoses and deaths. In 2010, 1 in every 20 people in the United
4 States age 12 and older—a total of 12 million people—reported using
5 prescription painkillers non-medically according to the National
6 Survey on Drug Use and Health. Based on the data from the Drug
7 Enforcement Administration, sales of these drugs to pharmacies and
8 health care providers have increased by more than 300 percent since
9 1999.
- 10 e. Prescription drug abuse is a silent epidemic that is stealing thousands
11 of lives and tearing apart communities and families across America.
- 12 f. Almost 5,500 people start to misuse prescription painkillers every
13 day.¹¹

14 54. The number of annual opioid prescriptions written in the United
15 States is now roughly equal to the number of adults in the population.¹²

16 55. Many Americans are now addicted to prescription opioids, and the
17 number of deaths due to prescription opioid overdose is unacceptable. In 2016,
18 drug overdoses killed roughly 64,000 people in the United States, an increase of
19 more than 22 percent over the 52,404 drug deaths recorded the previous year.¹³

20 56. Moreover, the CDC has identified addiction to prescription pain
21 medication as the strongest risk factor for heroin addiction. People who are
22 addicted to prescription opioid painkillers are forty times more likely to be
23 addicted to heroin.¹⁴

24 57. Heroin is pharmacologically similar to prescription opioids. The
25 majority of current heroin users report having used prescription opioids non-

26 ¹¹ See Press Release, Ctrs. for Disease Control and Prevention, U.S. Dep’t of
27 Health and Human Servs., Prescription Painkiller Overdoses at Epidemic Levels
28 (Nov. 1, 2011),
https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html.

29 ¹² See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*,
30 374 N. Eng. J. Med. 1480 (2016).

31 ¹³ See Ctrs. for Disease Control and Prevention, U.S. Dep’t of Health and Human
32 Servs., Provisional Counts of Drug Overdose Deaths, (August 8, 2016),
https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf.

33 ¹⁴ See Ctrs. for Disease Control and Prevention, U.S. Dep’t of Health and Human
34 Servs., *Today’s Heroin Epidemic*,
<https://www.cdc.gov/vitalsigns/heroin/index.html> (last updated July 7, 2015).

1 medically before they initiated heroin use. Available data indicates that the
 2 nonmedical use of prescription opioids is a strong risk factor for heroin use.¹⁵

3 58. The CDC reports that drug overdose deaths involving heroin
 4 continued to climb sharply, with heroin overdoses more than tripling in 4 years.
 5 This increase mirrors large increases in heroin use across the country and has been
 6 shown to be closely tied to opioid pain reliever misuse and dependence. ***Past***
 7 ***misuse of prescription opioids is the strongest risk factor for heroin initiation***
 8 ***and use,*** specifically among persons who report past-year dependence or abuse.
 9 The increased availability of heroin, combined with its relatively low price
 10 (compared with diverted prescription opioids) and high purity appear to be major
 11 drivers of the upward trend in heroin use and overdose.¹⁶

12 59. The societal costs of prescription drug abuse are “huge.”¹⁷

13 60. Across the nation, local governments are struggling with a
 14 pernicious, ever-expanding epidemic of opioid addiction and abuse. Every day,
 15 more than 90 Americans lose their lives after overdosing on opioids.¹⁸

16 61. The National Institute on Drug Abuse identifies misuse and addiction
 17 to opioids as “a serious national crisis that affects public health as well as social
 18 and economic welfare.”¹⁹ The economic burden of prescription opioid misuse
 19

20 ¹⁵ See Wilson M. Compton, Relationship Between Nonmedical Prescription-
 21 Opioid Use and Heroin, 374 N. Eng. J. Med. 154 (2016).

22 ¹⁶ See Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths—*
 23 *United States, 2000–2014*, 64 Morbidity & Mortality Wkly. Rep. 1378 (2016).

24 ¹⁷ See Amicus Curiae Brief of Healthcare Distribution Management Association in
 25 Support of Appellant Cardinal Health, Inc., *Cardinal Health, Inc. v. United States*
 26 *Dept. Justice*, No. 12-5061 (D.C. Cir. May 9, 2012), 2012 WL 1637016, at *10
 27 [hereinafter Brief of HDMA].

28 ¹⁸ Opioid Crisis, NIH, National Institute on Drug Abuse (available at
 https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis, last visited Sept. 19,
 2017) (“Opioid Crisis, NIH”) (citing at note 1 Rudd RA, Seth P, David F, Scholl L,
 29 *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–*
2015, MMWR MORB MORTAL WKLY REP. 2016;65,
 doi:10.15585/mmwr.mm655051e1).

30 ¹⁹ Opioid Crisis, NIH.

1 alone is \$78.5 billion a year, including the costs of healthcare, lost productivity,
 2 addiction treatment, and criminal justice expenditures.²⁰

3 62. The U.S. opioid epidemic is continuing, and drug overdose deaths
 4 nearly tripled during 1999–2014. Among 47,055 drug overdose deaths that
 5 occurred in 2014 in the United States, 28,647 (60.9%) involved an opioid.²¹

6 63. The rate of death from opioid overdose has quadrupled during the
 7 past 15 years in the United States. Nonfatal opioid overdoses that require medical
 8 care in a hospital or emergency department have increased by a factor of six in the
 9 past 15 years.²²

10 64. Every day brings a new revelation regarding the depth of the opioid
 11 plague: just to name one example, the New York Times reported in September
 12 2017 that the epidemic, which now claims 60,000 lives a year, is now killing
 13 babies and toddlers because ubiquitous, deadly opioids are “everywhere” and
 14 mistaken as candy.²³

15 65. In 2016, the President of the United States declared an opioid and
 16 heroin epidemic.²⁴

17 66. The epidemic of prescription pain medication and heroin deaths is
 18 devastating families and communities across the country.²⁵ Meanwhile, the
 19
 20

21 ²⁰ *Id.* (citing at note 2 Florence CS, Zhou C, Luo F, Xu L, *The Economic Burden*
 22 *of Prescription Opioid Overdose, Abuse, and Dependence in the United States,*
 23 2013, MED CARE 2016;54(10):901-906, doi:10.1097/MLR.0000000000000625).

24 ²¹ See Rose A. Rudd et al., Increases in Drug and Opioid-Involved Overdose
 25 Deaths—United States, 2010–2015, 65 Morbidity & Mortality Wkly. Rep. 1445
 26 (2016).

27 ²² See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—*
 28 *Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

29 ²³ Julie Turkewitz, ‘The Pills are Everywhere’: How the Opioid Crisis Claims Its
 30 Youngest Victims, N.Y. Times, Sept. 20, 2017 (“It’s a cancer,” said [grandmother
 31 of dead one-year old], of the nation’s opioid problem, ‘with tendrils that are going
 32 everywhere.’”).

33 ²⁴ See Proclamation No. 9499, 81 Fed. Reg. 65,173 (Sept. 16, 2016) (proclaiming
 34 “Prescription Opioid and Heroin Epidemic Awareness Week”).

1 manufacturers and distributors of prescription opioids extract billions of dollars of
 2 revenue from the addicted American public while public entities experience
 3 hundreds of millions of dollars of injury – if not more – caused by the reasonably
 4 foreseeable consequences of the prescription opioid addiction epidemic.

5 67. The prescription opioid manufacturers and distributors, including the
 6 Defendants, have continued their wrongful, intentional, and unlawful conduct,
 7 despite their knowledge that such conduct is causing and/or contributing to the
 8 national, state, and local opioid epidemic.

9 **2. The California Opioid Epidemic.**

10 68. California has been especially ravaged by the national opioid crisis.

11 69. More people die each year from drug overdoses in California than in
 12 any other state.²⁶ The State's death rate has continued to climb, increasing by 30
 13 percent from 1999 to 2015, according to the Center for Disease Control (CDC).²⁷

14 70. In 2016, 1,925 Californians died due to prescription opioids.²⁸ This
 15 number is on par with other recent years: in 2015, 1,966 deaths in California were
 16 due just to prescription opioids (not including heroin); in 2014 that number was
 17 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians
 18 died from a prescription opioid overdose.²⁹

19
 20

²⁵ See Presidential Memorandum – Addressing Prescription Drug Abuse and
 21 Heroin Use, 2015 Daily Comp. Pres. Doc. 743 (Oct. 21, 2015),
<https://www.gpo.gov/fdsys/pkg/DCPD-201500743/pdf/DCPD-201500743.pdf>.

22

²⁶ Kristina Davis, “How California ranks in the nation’s opioid epidemic,” *The San
 23 Diego Union-Tribune* (Nov. 8, 2017) available at
<http://www.sandiegouniontribune.com/news/health/sd-me-opioid-conference-20171108-story.html> (last visited March 2, 2018).

24

²⁷ Soumya Karlamangla, “California’s opioid death rate is among the national’s
 25 lowest. Experts aren’t sure why,” *The Los Angeles Times* (Oct. 27, 2017) available
 26 at [http://www.latimes.com/health/la-me-ln-california-opioids-20171026-htmstory.html](http://www.latimes.com/health/la-me-ln-california-opioids-20171026-htmlstory.html) (last visited March 2, 2018).

27

²⁸ Davis, *supra*.

28

²⁹ California Department of Public Health, *California Opioid Overdose
 Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last
 visited March 2, 2018).

1 71. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was
2 a factor in at least 234 of them.³⁰ This is an increase of 47 percent for 2016.³¹
3 Heroin-related deaths have risen by 67 percent in California since 2006.³²

4 72. The high number of deaths are due in part to the extraordinary
5 number of opioids prescribed in the State. Over 23.6 million prescriptions for
6 opioids were written in California in just 2016.³³

7 73. The California Department of Public Health tracks the number of
8 reported hospitalizations and emergency department visits due to prescription
9 opioids.³⁴ In 2015, the last year for which information is currently available,
10 California had 3,935 emergency department visits and 4,095 hospitalizations
11 related to prescription opioid overdoses (excluding heroin).³⁵ The numbers were
12 even higher in 2014, when 4,106 people visited the emergency department and
13 4,482 people were hospitalized due to prescription opioid abuse.³⁶ In 2013, there
14 were 3,964 emergency department visits and 4,344 hospitalizations for
15 prescription opioid overdoses.³⁷ When emergency visits and hospitalizations
16 include heroin, the numbers are even higher.³⁸

17
18
19 ³⁰ Davis, *supra*.

20 ³¹ Karlamangla, *supra*.

21 ³² California Department of Public Health, *State of California Strategies to Address*
22 *Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in California*
23 at 3 (June 2016), available at
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

24 ³³ California Department of Public Health, *California Opioid Overdose*
25 *Surveillance Dashboard*, *supra*.

26 ³⁴ *Id.*

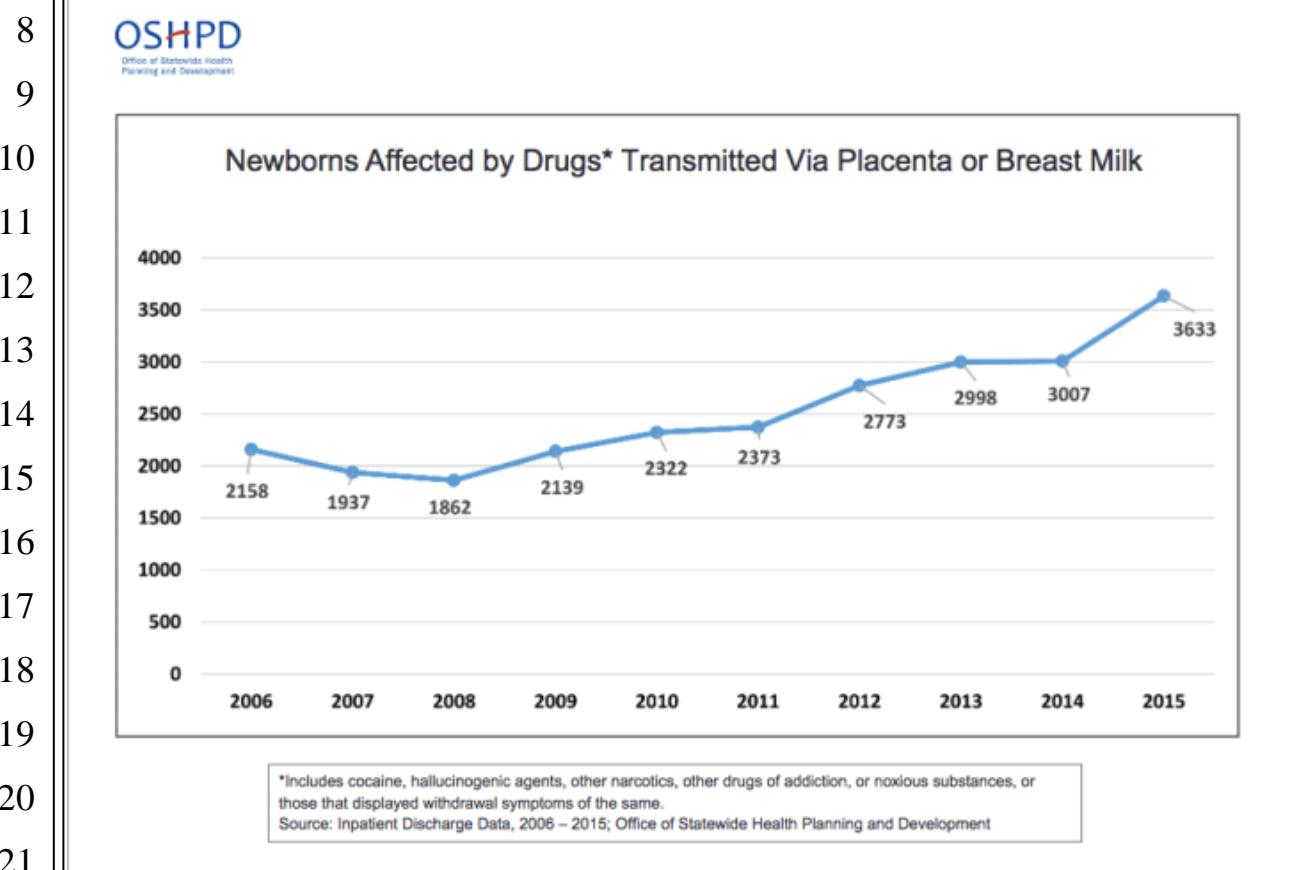
27 ³⁵ *Id.*

28 ³⁶ *Id.*

29 ³⁷ *Id.*

30 ³⁸ *Id.*

1 74. Neonatal Abstinence Syndrome (NAS), a collection of symptoms
 2 newborn babies experience withdrawing from opioid medications taken by the
 3 mother, has increased dramatically in California, with the rate of infants born with
 4 NAS more than tripling from 2008 to 2013.³⁹ While the number of affected
 5 newborns rose from 1,862 in 2008 to 3,007 in 2014, that number jumped by
 6 another 21 percent in 2015.⁴⁰ This is despite a steady decline in the overall
 7 number of birth in California during that same time.⁴¹



³⁹ California Child Welfare Co-Investment Partnership, *A Matter of Substance, Challenges and Responses to Parental Substance Use in Child Welfare*, at 5 (Summer 2017), available at http://www.chhs.ca.gov/Child%20Welfare/CCW_Co-Invest_Insights_DIGITAL_FINAL_053017.pdf (last visited March 2, 2018).

⁴⁰ Cheryl Clark, “Report Shows Spike in San Diego County Babies Born with Drugs in their Systems,” KPBS (April 17, 2017), available at <http://www.kpbs.org/news/2017/apr/17/report-shows-spike-san-diego-county-babies-born-dr/> (last visited March 2, 2018).

⁴¹ *Id.*

1 75. Reports from California's Office of Statewide Health Planning,
2 which collects data from licensed health care facilities, have shown a 95 percent
3 increase between 2008 and 2015 of newborns affected by drugs transmitted via
4 placenta or breast milk.⁴²

5 76. The opioid epidemic has also had an impact on crime in California.
6 Pharmacy robberies have gone up by 163 percent in California over the last two
7 years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in
8 2016 and, through mid-November of 2017, that number had climbed to 237.⁴³
9 Most perpetrators were after prescription opioids.⁴⁴ In addition, fentanyl seizures
10 at California ports increased 266 percent in fiscal year 2017.⁴⁵

11 **3. The Opioid Epidemic in Plaintiffs' Community.**

12 77. The opioid epidemic is particularly devastating in Plaintiffs'
13 Community.

14 78. In 2016, the County had an opioid overdose death rate of 13.4, the
15 eighth highest in the State.⁴⁶ In 2015, the County's opioid overdose death rate
16 was in the highest quartile in the State.⁴⁷

17
18
19 ⁴² California Child Welfare Co-Investment Partnership, *supra*, at 3.

20 ⁴³ Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at
21 <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited
March 2, 2018)).

22 ⁴⁴ *Id.*

23 ⁴⁵ United States Department of Justice, The United States Attorney's Office,
24 Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb.
25 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

26 ⁴⁶ California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last visited April 23, 2018) (Trinity County specific page).

27 ⁴⁷ Public Health Institute, Tackling An Epidemic: An Assessment of the California
28 Opioid Safety Coalitions Network, at p. 11, available at
<https://www.phi.org/uploads/application/files/bt93oju0nrnbsmjhpdw692ljgu0d27ttdpzxmbclj7cxq99alz.pdf> (last visited April 20, 2018).

1 79. Prescription opioids have also been responsible for a high rate of
 2 emergency department visits in the County. In 2016, Trinity County had a rate of
 3 40.8 emergency department visits due to opioid overdoses (excluding heroin) per
 4 100,000 people, the fourth highest rate in the State that year.⁴⁸

5 80. In 2016, an estimated seven percent of the population aged 12 and up
 6 in Trinity County misused opioids and about 1.3 percent had an opioid use
 7 disorder.⁴⁹

8 81. The CDC has tracked prescription rates per county in the United
 9 States, identifying the geographic “hotspots” for rates of opioid prescriptions.⁵⁰
 10 The CDC has calculated the geographic distribution at county levels of opioid
 11 prescriptions dispensed per 100 persons,⁵¹ revealing that Trinity County has been
 12 a consistent hotspot over at least the past decade.

13 82. The CDC’s statistics prove that the opioid prescription rates in
 14 Trinity County have exceeded any legitimate medical, scientific, or industrial
 15 purpose. The overall opioid prescribing rate nationally in 2016 was 66.5
 16 prescriptions per 100 people and 44.8 in California.⁵² However, in Trinity County,
 17 California, the 2016 prescription rate was 98.5 per 100 people.⁵³ This is down

18
 19 ⁴⁸ California Department of Public Health, *California Opioid Overdose*
 20 *Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last
 21 visited April 20, 2018) (Trinity County specific page).

22 ⁴⁹ Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, “County-Level
 23 Estimates of Opioid Use Disorder and Treatment Needs in California,” *The Urban*
 24 *Institute*, March 19, 2018, available at
<https://www.urban.org/sites/default/files/trinity.pdf> (last visited April 23, 2018).

25 ⁵⁰ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 26 2017).

27 ⁵¹ *Id.*

28 ⁵² *Id. See also* U.S. State Prescribing Rates, 2016, available at
<https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,
 29 2018).

30 ⁵³ U.S. County Prescribing Rates, 2016, (reporting for “Trinity, CA” here and
 31 below) CDC available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,
 32 2018).

1 from the 2015 prescribing rate for Trinity County which was 110.2 per 100 people
 2 – more than one prescription for every man, woman and child in Trinity County.⁵⁴

3 83. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions
 4 were not an aberration for Trinity County. Consistently, the opioid prescribing
 5 rates in Trinity County have been significantly greater than the national and state
 6 averages, and well more than one prescription per person living in the County.
 7 Compared to a national average of 75.6 opioid prescriptions per 100 people in
 8 2014⁵⁵ and 52.7 in California,⁵⁶ the Trinity County opioid prescription rate was
 9 119.6 per 100 people, more than double the State prescribing rate.⁵⁷ In 2013, the
 10 national average was 78.1 opioid prescriptions per 100 people,⁵⁸ but the opioid
 11 prescription rate in Trinity County was 117 per 100 people.⁵⁹ Compared to a
 12 national average of 81.3 opioid prescriptions per 100 people in 2012,⁶⁰ the opioid
 13 prescription rate in Trinity County was 126.7 per 100 people that year.⁶¹ In 2011,

14
 15 ⁵⁴ U.S. County Prescribing Rates, 2015, CDC, available at
 16 <https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,
 2018).

17 ⁵⁵ U.S. Prescribing Rate Maps, CDC, available at
 18 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

19 ⁵⁶ U.S. State Prescribing Rates, 2014, CDC, available at
 20 <https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,
 2017).

21 ⁵⁷ U.S. County Prescribing Rates, 2014, CDC, available at
 22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,
 2018).

23 ⁵⁸ U.S. Prescribing Rate Maps, CDC, available at
 24 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

25 ⁵⁹ U.S. County Prescribing Rates, 2013, CDC, available at
 26 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,
 2018).

27 ⁶⁰ U.S. Prescribing Rate Maps, CDC, available at
 28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

⁶¹ U.S. County Prescribing Rates, 2012, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,
 2018).

1 the national average was 80.9 opioid prescriptions per 100 people,⁶² but the opioid
 2 prescription rate in Trinity County was 135.6 per 100 people.⁶³ Compared to a
 3 national average of 81.2 opioid prescriptions per 100 people in 2010,⁶⁴ the Trinity
 4 County opioid prescription rate was 144.9 per 100 people.⁶⁵ In 2009, the national
 5 average was 79.5 opioid prescriptions per 100 people,⁶⁶ but the rate in Trinity
 6 County was 121.4 per 100.⁶⁷ Compared to a national average of 78.2 opioid
 7 prescriptions per 100 people in 2008⁶⁸ and 55.1 in California,⁶⁹ the Trinity County
 8 rate was 116.8 per 100 people.⁷⁰ In 2007, the national average was 75.9 opioid
 9 prescriptions per 100 people,⁷¹ but the Trinity County rate was 117.9 per 100

10

11 ⁶² U.S. Prescribing Rate Maps, CDC, available at
 12 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 13 2017).

14 ⁶³ U.S. County Prescribing Rates, 2011, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,
 15 2018).

16 ⁶⁴ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 17 2017).

18 ⁶⁵ U.S. County Prescribing Rates, 2010, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18,
 19 2018).

20 ⁶⁶ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 21 2017).

22 ⁶⁷ U.S. County Prescribing Rates, 2009, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18,
 23 2018).

24 ⁶⁸ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 25 2017).

26 ⁶⁹ U.S. State Prescribing Rates, 2008, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11,
 27 2017).

28 ⁷⁰ U.S. County Prescribing Rates, 2008, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18,
 29 2018).

⁷¹ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,,
 30 2017).

1 people.⁷² Compared to a national average of 72.4 opioid prescriptions per 100
2 people prescribed opioids in 2006,⁷³ the Trinity County rate was 120.5 per 100
3 people.⁷⁴

4 84. The sheer volume of these dangerously addictive drugs was destined
5 to create the present crisis of addiction, abuse, and overdose deaths.

6 **B. THE MANUFACTURER DEFENDANTS' FALSE, DECEPTIVE,**
7 **AND UNFAIR MARKETING OF OPIOIDS.**

8 85. The opioid epidemic did not happen by accident.

9 86. Before the 1990s, generally accepted standards of medical practice
10 dictated that opioids should only be used short-term for acute pain, pain relating to
11 recovery from surgery, or for cancer or palliative (end-of-life) care. Due to the
12 lack of evidence that opioids improved patients' ability to overcome pain and
13 function, coupled with evidence of greater pain complaints as patients developed
14 tolerance to opioids over time and the serious risk of addiction and other side
15 effects, the use of opioids for chronic pain was discouraged or prohibited. As a
16 result, doctors generally did not prescribe opioids for chronic pain.

17 87. Each Manufacturer Defendant has conducted, and has continued to
18 conduct, a marketing scheme designed to persuade doctors and patients that
19 opioids can and should be used for chronic pain, resulting in opioid treatment for a
20 far broader group of patients who are much more likely to become addicted and
21 suffer other adverse effects from the long-term use of opioids. In connection with
22 this scheme, each Manufacturer Defendant spent, and continues to spend, millions

24 ⁷² U.S. County Prescribing Rates, 2007, CDC, available at
25 <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18,
26 2018).

27 ⁷³ U.S. Prescribing Rate Maps, CDC, available at
28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
29 2017).

30 ⁷⁴ U.S. County Prescribing Rates, 2006, CDC, available at
31 <https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18,
32 2018).

1 of dollars on promotional activities and materials that falsely deny or trivialize the
2 risks of opioids while overstating the benefits of using them for chronic pain.

3 88. The Manufacturer Defendants have made false and misleading
4 claims, contrary to the language on their drugs' labels, regarding the risks of using
5 their drugs that: (1) downplayed the serious risk of addiction; (2) created and
6 promoted the concept of "pseudoaddiction" when signs of actual addiction began
7 appearing and advocated that the signs of addiction should be treated with more
8 opioids; (3) exaggerated the effectiveness of screening tools to prevent addiction;
9 (4) claimed that opioid dependence and withdrawal are easily managed; (5) denied
10 the risks of higher opioid dosages; and (6) exaggerated the effectiveness of
11 "abuse-deterrant" opioid formulations to prevent abuse and addiction. The
12 Manufacturer Defendants have also falsely touted the benefits of long-term opioid
13 use, including the supposed ability of opioids to improve function and quality of
14 life, even though there was no scientifically reliable evidence to support the
15 Manufacturer Defendants' claims.

16 89. The Manufacturer Defendants have disseminated these common
17 messages to reverse the popular and medical understanding of opioids and risks of
18 opioid use. They disseminated these messages directly, through their sales
19 representatives, in speaker groups led by physicians the Manufacturer Defendants
20 recruited for their support of their marketing messages, and through unbranded
21 marketing and industry-funded front groups.

22 90. The Manufacturer Defendants' efforts have been wildly successful.
23 Opioids are now the most prescribed class of drugs. Globally, opioid sales
24 generated \$11 billion in revenue for drug companies in 2010 alone; sales in the
25 United States have exceeded \$8 billion in revenue annually since 2009.⁷⁵ In an
26
27

28 ⁷⁵ See Katherine Eban, *Oxycontin: Purdue Pharma's Painful Medicine*, Fortune, Nov. 9, 2011, <http://fortune.com/2011/11/09/oxycontin-purdue-pharma-painful-medicine/>; David Crow, *Drugmakers Hooked on \$10bn Opioid Habit*, Fin. Times,

1 open letter to the nation’s physicians in August 2016, the then-U.S. Surgeon
 2 General expressly connected this “urgent health crisis” to “heavy marketing of
 3 opioids to doctors . . . [m]any of [whom] were even taught – incorrectly – that
 4 opioids are not addictive when prescribed for legitimate pain.”⁷⁶ This epidemic
 5 has resulted in a flood of prescription opioids available for illicit use or sale (the
 6 supply), and a population of patients physically and psychologically dependent on
 7 them (the demand). And when those patients can no longer afford or obtain
 8 opioids from licensed dispensaries, they often turn to the street to buy prescription
 9 opioids or even non-prescription opioids, like heroin.

10 91. The Manufacturer Defendants intentionally continued their conduct,
 11 as alleged herein, with knowledge that such conduct was creating the opioid
 12 nuisance and causing the harms and damages alleged herein.

13 **1. Each Manufacturer Defendant Used Multiple Avenues to
 14 Disseminate Their False and Deceptive Statements about Opioids.**

15 92. The Manufacturer Defendants spread their false and deceptive
 16 statements by marketing their branded opioids directly to doctors and patients in
 17 and around the State, including in Plaintiffs’ Community. Defendants also
 18 deployed seemingly unbiased and independent third parties that they controlled to
 19 spread their false and deceptive statements about the risks and benefits of opioids
 20 for the treatment of chronic pain throughout the State and Plaintiffs’ Community.

21 93. The Manufacturer Defendants employed the same marketing plans
 22 and strategies and deployed the same messages in and around the State, including
 23 in Plaintiffs’ Community, as they did nationwide. Across the pharmaceutical
 24 industry, “core message” development is funded and overseen on a national basis

25
 26
 27 Aug. 10, 2016, <https://www.ft.com/content/f6e989a8-5dac-11e6-bb77-a121aa8abd95>.

28 ⁷⁶ Letter from Vivek H. Murthy, U.S. Surgeon General (Aug. 2016),
<http://turnthetiderx.org/>.

1 by corporate headquarters. This comprehensive approach ensures that the
2 Manufacturer Defendants' messages are accurately and consistently delivered
3 across marketing channels – including detailing visits, speaker events, and
4 advertising – and in each sales territory. The Manufacturer Defendants consider
5 this high level of coordination and uniformity crucial to successfully marketing
6 their drugs.

7 94. The Manufacturer Defendants ensure marketing consistency
8 nationwide through national and regional sales representative training; national
9 training of local medical liaisons, the company employees who respond to
10 physician inquiries; centralized speaker training; single sets of visual aids, speaker
11 slide decks and sales training materials; and nationally coordinated advertising.
12 The Manufacturer Defendants' sales representatives and physician speakers were
13 required to stick to prescribed talking points, sales messages, and slide decks, and
14 supervisors rode along with them periodically to both check on their performance
15 and compliance.

16 **a) Direct Marketing.**

17 95. The Manufacturer Defendants' direct marketing of opioids generally
18 proceeded on two tracks. First, each Manufacturer Defendant conducted and
19 continues to conduct advertising campaigns touting the purported benefits of their
20 branded drugs. For example, upon information and belief, the Manufacturer
21 Defendants spent more than \$14 million on medical journal advertising of opioids
22 in 2011, nearly triple what they spent in 2001.

23 96. Many of the Manufacturer Defendants' branded ads deceptively
24 portrayed the benefits of opioids for chronic pain. For example, Endo distributed
25 and made available on its website opana.com a pamphlet promoting Opana ER
26 with photographs depicting patients with physically demanding jobs like
27 construction worker, chef, and teacher, misleadingly implying that the drug would
28 provide long-term pain-relief and functional improvement. Upon information and

1 belief, Purdue also ran a series of ads, called “Pain vignettes,” for OxyContin in
2 2012 in medical journals. These ads featured chronic pain patients and
3 recommended OxyContin for each. One ad described a “54-year-old writer with
4 osteoarthritis of the hands” and implied that OxyContin would help the writer
5 work more effectively.

6 97. Second, each Manufacturer Defendant promoted the use of opioids
7 for chronic pain through “detailers” – sales representatives who visited individual
8 doctors and medical staff in their offices – and small-group speaker programs. The
9 Manufacturer Defendants have not corrected this misinformation. Instead, each
10 Defendant devoted massive resources to direct sales contacts with doctors. Upon
11 information and belief, in 2014 alone, the Manufacturer Defendants spent in
12 excess of \$168 million on detailing branded opioids to doctors, more than twice
13 what they spent on detailing in 2000.

14 98. The Manufacturer Defendants’ detailing to doctors is effective.
15 Numerous studies indicate that marketing impacts prescribing habits, with face-to-
16 face detailing having the greatest influence. Even without such studies, the
17 Manufacturer Defendants purchase, manipulate and analyze some of the most
18 sophisticated data available in any industry, data available from IMS Health
19 Holdings, Inc., to track, precisely, the rates of initial prescribing and renewal by
20 individual doctor, which in turn allows them to target, tailor, and monitor the
21 impact of their core messages. Thus, the Manufacturer Defendants know their
22 detailing to doctors is effective.

23 99. The Manufacturer Defendants’ detailers have been reprimanded for
24 their deceptive promotions. In March 2010, for example, the FDA found that
25 Actavis had been distributing promotional materials that “minimize[] the risks
26 associated with Kadian and misleadingly suggest[] that Kadian is safer than has
27 been demonstrated.” Those materials in particular “fail to reveal warnings

28

1 regarding potentially fatal abuse of opioids, use by individuals other than the
2 patient for whom the drug was prescribed.”⁷⁷

3 **b) Indirect Marketing.**

4 100. The Manufacturer Defendants indirectly marketed their opioids using
5 unbranded advertising, paid speakers and “key opinion leaders” (“KOLs”), and
6 industry-funded organizations posing as neutral and credible professional societies
7 and patient advocacy groups (referred to hereinafter as “Front Groups”).

8 101. The Manufacturer Defendants deceptively marketed opioids in the
9 State and Plaintiffs’ Community through unbranded advertising – e.g., advertising
10 that promotes opioid use generally but does not name a specific opioid. This
11 advertising was ostensibly created and disseminated by independent third parties.
12 But by funding, directing, reviewing, editing, and distributing this unbranded
13 advertising, the Manufacturer Defendants controlled the deceptive messages
14 disseminated by these third parties and acted in concert with them to falsely and
15 misleadingly promote opioids for the treatment of chronic pain. Much as
16 Defendants controlled the distribution of their “core messages” via their own
17 detailers and speaker programs, the Manufacturer Defendants similarly controlled
18 the distribution of these messages in scientific publications, treatment guidelines,
19 Continuing Medical Education (“CME”) programs, and medical conferences and
20 seminars. To this end, the Manufacturer Defendants used third-party public
21 relations firms to help control those messages when they originated from third-
22 parties.

23 102. The Manufacturer Defendants marketed through third-party,
24 unbranded advertising to avoid regulatory scrutiny because that advertising is not
25 submitted to and typically is not reviewed by the FDA. The Manufacturer

27 28 ⁷⁷ Letter from Thomas Abrams, Dir., Div. of Drug Mktg., Advert., & Commc’ns,
U.S. Food & Drug Admin., to Doug Boothe, CEO, Actavis Elizabeth LLC (Feb.
18, 2010),
<http://www.fdanews.com/ext/resources/files/archives/a/ActavisElizabethLLC.pdf>.

1 Defendants also used third-party, unbranded advertising to give the false
2 appearance that the deceptive messages came from an independent and objective
3 source. Like the tobacco companies, the Manufacturer Defendants used third
4 parties that they funded, directed, and controlled to carry out and conceal their
5 scheme to deceive doctors and patients about the risks and benefits of long term
6 opioid use for chronic pain.

7 103. Defendants also identified doctors to serve, for payment, on their
8 speakers' bureaus and to attend programs with speakers and meals paid for by
9 Defendants. These speaker programs provided: (1) an incentive for doctors to
10 prescribe a particular opioid (so they might be selected to promote the drug); (2)
11 recognition and compensation for the doctors selected as speakers; and (3) an
12 opportunity to promote the drug through the speaker to his or her peers. These
13 speakers give the false impression that they are providing unbiased and medically
14 accurate presentations when they are, in fact, presenting a script prepared by
15 Defendants. On information and belief, these presentations conveyed misleading
16 information, omitted material information, and failed to correct Defendants' prior
17 misrepresentations about the risks and benefits of opioids.

18 104. Borrowing a page from Big Tobacco's playbook, the Manufacturer
19 Defendants worked through third parties they controlled by: (a) funding, assisting,
20 encouraging, and directing doctors who served as KOLS, and (b) funding,
21 assisting, directing, and encouraging seemingly neutral and credible Front Groups.
22 The Manufacturer Defendants then worked together with those KOLs and Front
23 Groups to taint the sources that doctors and patients relied on for ostensibly
24 "neutral" guidance, such as treatment guidelines, CME programs, medical
25 conferences and seminars, and scientific articles. Thus, working individually and
26 collectively, and through these Front Groups and KOLs, the Manufacturer
27 Defendants persuaded doctors and patients that what they have long known – that
28

1 opioids are addictive drugs, unsafe in most circumstances for long-term use – was
2 untrue, and that the compassionate treatment of pain required opioids.

3 105. In 2007, multiple States sued Purdue for engaging in unfair and
4 deceptive practices in its marketing, promotion, and sale of OxyContin. Certain
5 states settled their claims in a series of Consent Judgments that prohibited Purdue
6 from making misrepresentations in the promotion and marketing of OxyContin in
7 the future. By using indirect marketing strategies, however, Purdue intentionally
8 circumvented these restrictions. Such actions include contributing to the creation
9 of misleading publications and prescribing guidelines which lack reliable
10 scientific basis, and promoting prescribing practices which have worsened the
11 opioid crisis.

12 106. Pro-opioid doctors are one of the most important avenues that the
13 Manufacturer Defendants use to spread their false and deceptive statements about
14 the risks and benefits of long-term opioid use. The Manufacturer Defendants
15 know that doctors rely heavily and less critically on their peers for guidance, and
16 KOLs provide the false appearance of unbiased and reliable support for chronic
17 opioid therapy. For example, the State of New York found in its settlement with
18 Purdue that the Purdue website “In the Face of Pain” failed to disclose that doctors
19 who provided testimonials on the site were paid by Purdue and concluded that
20 Purdue’s failure to disclose these financial connections potentially misled
21 consumers regarding the objectivity of the testimonials.

22 107. Defendants utilized many KOLs, including many of the same ones.

23 108. Dr. Russell Portenoy, former Chairman of the Department of Pain
24 Medicine and Palliative Care at Beth Israel Medical Center in New York, is one
25 example of a KOL whom the Manufacturer Defendants identified and promoted to
26 further their marketing campaign. Dr. Portenoy received research support,
27 consulting fees, and honoraria from Cephalon, Endo, Janssen, and Purdue (among
28 others), and was a paid consultant to Cephalon and Purdue. Dr. Portenoy was

1 instrumental in opening the door for the regular use of opioids to treat chronic
2 pain. He served on the American Pain Society (“APS”) / American Academy of
3 Pain Medicine (“AAPM”) Guidelines Committees, which endorsed the use of
4 opioids to treat chronic pain, first in 1996 and again in 2009. He was also a
5 member of the board of the American Pain Foundation (“APF”), an advocacy
6 organization almost entirely funded by the Manufacturer Defendants.

7 109. Dr. Portenoy also made frequent media appearances promoting
8 opioids and spreading misrepresentations, such as his claim that “the likelihood
9 that the treatment of pain using an opioid drug which is prescribed by a doctor
10 will lead to addiction is extremely low.” He appeared on Good Morning America
11 in 2010 to discuss the use of opioids long-term to treat chronic pain. On this
12 widely-watched program, broadcast across the country, Dr. Portenoy claimed:
13 “Addiction, when treating pain, is distinctly uncommon. If a person does not have
14 a history, a personal history, of substance abuse, and does not have a history in the
15 family of substance abuse, and does not have a very major psychiatric disorder,
16 most doctors can feel very assured that that person is not going to become
17 addicted.”⁷⁸

18 110. Dr. Portenoy later admitted that he “gave innumerable lectures in the
19 late 1980s and ‘90s about addiction that weren’t true.” These lectures falsely
20 claimed that fewer than 1% of patients would become addicted to opioids.
21 According to Dr. Portenoy, because the primary goal was to “destigmatize”
22 opioids, he and other doctors promoting them overstated their benefits and glossed
23 over their risks. Dr. Portenoy also conceded that “[d]ata about the effectiveness of
24 opioids does not exist.”⁷⁹ Portenoy candidly stated: “Did I teach about pain

⁷⁸ Good Morning America (ABC television broadcast Aug. 30, 2010).

⁷⁹ Thomas Catan & Evan Perez, *A Pain-Drug Champion Has Second Thoughts*, Wall St. J., Dec. 17, 2012, <https://www.wsj.com/articles/SB10001424127887324478304578173342657044604>.

1 management, specifically about opioid therapy, in a way that reflects
2 misinformation? Well, . . . I guess I did.”⁸⁰

3 111. Another KOL, Dr. Lynn Webster, was the co-founder and Chief
4 Medical Director of Lifetree Clinical Research, an otherwise unknown pain clinic
5 in Salt Lake City, Utah. Dr. Webster was President of the AAPM in 2013. He is a
6 Senior Editor of Pain Medicine, the same journal that published Endo special
7 advertising supplements touting Opana ER. Dr. Webster was the author of
8 numerous CMEs sponsored by Cephalon, Endo, and Purdue. At the same time,
9 Dr. Webster was receiving significant funding from the Manufacturer Defendants
10 (including nearly \$2 million from Cephalon).

11 112. During a portion of his time as a KOL, Dr. Webster was under
12 investigation for overprescribing by the U.S. Department of Justice’s Drug
13 Enforcement Agency, which raided his clinic in 2010. Although the investigation
14 was closed without charges in 2014, more than 20 of Dr. Webster’s former
15 patients at the Lifetree Clinic have died of opioid overdoses.

16 113. Ironically, Dr. Webster created and promoted the Opioid Risk Tool, a
17 five question, one-minute screening tool relying on patient self-reports that
18 purportedly allows doctors to manage the risk that their patients will become
19 addicted to or abuse opioids. The claimed ability to pre-sort patients likely to
20 become addicted is an important tool in giving doctors confidence to prescribe
21 opioids long-term, and for this reason, references to screening appear in various
22 industry-supported guidelines. Versions of Dr. Webster’s Opioid Risk Tool appear
23 on, or are linked to, websites run by Endo, Janssen, and Purdue. Unaware of the
24 flawed science and industry bias underlying this tool, certain states and public
25 entities have incorporated the Opioid Risk Tool into their own guidelines,

26

27

28

⁸⁰ *Id.*

1 indicating, also, their reliance on the Manufacturer Defendants and those under
 2 their influence and control.

3 114. In 2011, Dr. Webster presented, via webinar, a program sponsored by
 4 Purdue entitled “Managing Patient’s Opioid Use: Balancing the Need and the
 5 Risk.” Dr. Webster recommended use of risk screening tools, urine testing, and
 6 patient agreements as a way to prevent “overuse of prescriptions” and “overdose
 7 deaths.” This webinar was available to and was intended to reach doctors in the
 8 State and doctors treating members of Plaintiffs’ Community.⁸¹

9 115. Dr. Webster also was a leading proponent of the concept of
 10 “pseudoaddiction,” the notion that addictive behaviors should be seen not as
 11 warnings, but as indications of undertreated pain. In Dr. Webster’s description, the
 12 only way to differentiate the two was to increase a patient’s dose of opioids. As he
 13 and co-author Beth Dove wrote in their 2007 book *Avoiding Opioid Abuse While*
 14 *Managing Pain*—a book that is still available online—when faced with signs of
 15 aberrant behavior, increasing the dose “in most cases . . . should be the clinician’s
 16 first response.”⁸² Upon information and belief, Endo distributed this book to
 17 doctors. Years later, Dr. Webster reversed himself, acknowledging that
 18 “[pseudoaddiction] obviously became too much of an excuse to give patients more
 19 medication.”⁸³

20 116. The Manufacturer Defendants also entered into arrangements with
 21 seemingly unbiased and independent patient and professional organizations to
 22

23 ⁸¹ See Emerging Solutions in Pain, *Managing Patient’s Opioid Use: Balancing the*
 24 *Need and the Risk*, http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209 (last visited Aug. 22, 2017).

25 ⁸² Lynn Webster & Beth Dove, *Avoiding Opioid Abuse While Managing Pain* (2007).

26 ⁸³ John Fauber, *Painkiller Boom Fueled by Networking*, Milwaukee Wisc. J. Sentinel, Feb. 18, 2012, <http://archive.jsonline.com/watchdog/watchdogreports/painkiller-boom-fueled-by-networking-dp3p2rn-139609053.html>.

1 promote opioids for the treatment of chronic pain. Under the direction and control
 2 of the Manufacturer Defendants, these “Front Groups” generated treatment
 3 guidelines, unbranded materials, and programs that favored chronic opioid
 4 therapy. They also assisted the Manufacturer Defendants by responding to
 5 negative articles, by advocating against regulatory changes that would limit opioid
 6 prescribing in accordance with the scientific evidence, and by conducting outreach
 7 to vulnerable patient populations targeted by the Manufacturer Defendants.

8 117. These Front Groups depended on the Manufacturer Defendants for
 9 funding and, in some cases, for survival. The Manufacturer Defendants also
 10 exercised control over programs and materials created by these groups by
 11 collaborating on, editing, and approving their content, and by funding their
 12 dissemination. In doing so, the Manufacturer Defendants made sure that the Front
 13 Groups would generate only the messages that the Manufacturer Defendants
 14 wanted to distribute. Despite this, the Front Groups held themselves out as
 15 independent and serving the needs of their members – whether patients suffering
 16 from pain or doctors treating those patients.

17 118. Defendants Cephalon, Endo, Janssen, and Purdue, in particular,
 18 utilized many Front Groups, including many of the same ones. Several of the most
 19 prominent are described below, but there are many others, including the American
 20 Pain Society (“APS”), American Geriatrics Society (“AGS”), the Federation of
 21 State Medical Boards (“FSMB”), American Chronic Pain Association (“ACPA”),
 22 the Center for Practical Bioethics (“CPB”), the U.S. Pain Foundation (“USPF”)
 23 and Pain & Policy Studies Group (“PPSG”).⁸⁴

24
 25
 26 84 See generally, e.g., Letter from Sen. Ron Wyden, U.S. Senate Comm. on Fin., to
 27 Sec. Thomas E. Price, U.S. Dep’t of Health and Human Servs., (May 5, 2015),
<https://www.finance.senate.gov/imo/media/doc/050517%20Senator%20Wyden%20to%20Secretary%20Price%20re%20FDA%20Opioid%20Prescriber%20Working%20Group.pdf>.

1 119. The most prominent of the Manufacturer Defendants' Front Groups
2 was the American Pain Foundation ("APF"), which, upon information and belief,
3 received more than \$10 million in funding from opioid manufacturers from 2007
4 until it closed its doors in May 2012, primarily from Endo and Purdue. APF
5 issued education guides for patients, reporters, and policymakers that touted the
6 benefits of opioids for chronic pain and trivialized their risks, particularly the risk
7 of addiction. APF also launched a campaign to promote opioids for returning
8 veterans, which has contributed to high rates of addiction and other adverse
9 outcomes – including death – among returning soldiers. APF also engaged in a
10 significant multimedia campaign – through radio, television and the internet – to
11 educate patients about their "right" to pain treatment, namely opioids. All of the
12 programs and materials were available nationally and were intended to reach
13 citizens of the State and Plaintiffs' Community.

14 120. In 2009 and 2010, more than 80% of APF's operating budget came
15 from pharmaceutical industry sources. Including industry grants for specific
16 projects, APF received about \$2.3 million from industry sources out of total
17 income of about \$2.85 million in 2009; its budget for 2010 projected receipts of
18 roughly \$2.9 million from drug companies, out of total income of about \$3.5
19 million. By 2011, upon information and belief, APF was entirely dependent on
20 incoming grants from defendants Purdue, Cephalon, Endo, and others to avoid
21 using its line of credit.

22 121. APF held itself out as an independent patient advocacy organization.
23 It often engaged in grassroots lobbying against various legislative initiatives that
24 might limit opioid prescribing, and thus the profitability of its sponsors. Upon
25 information and belief, it was often called upon to provide "patient
26 representatives" for the Manufacturer Defendants' promotional activities,
27 including for Purdue's Partners Against Pain and Janssen's Let's Talk Pain. APF
28 functioned largely as an advocate for the interests of the Manufacturer

1 Defendants, not patients. Indeed, upon information and belief, as early as 2001,
 2 Purdue told APF that the basis of a grant was Purdue’s desire to “strategically
 3 align its investments in nonprofit organizations that share [its] business interests.”

4 122. Plaintiffs are informed and believe that on several occasions,
 5 representatives of the Manufacturer Defendants, often at informal meetings at
 6 conferences, suggested activities and publications for APF to pursue. APF then
 7 submitted grant proposals seeking to fund these activities and publications,
 8 knowing that drug companies would support projects conceived as a result of
 9 these communications.

10 123. The U.S. Senate Finance Committee began looking into APF in May
 11 2012 to determine the links, financial and otherwise, between the organization and
 12 the manufacturers of opioid painkillers. The investigation caused considerable
 13 damage to APF’s credibility as an objective and neutral third party, and the
 14 Manufacturer Defendants stopped funding it. Within days of being targeted by
 15 Senate investigation, APF’s board voted to dissolve the organization “due to
 16 irreparable economic circumstances.” APF “cease[d] to exist, effective
 17 immediately.”⁸⁵

18 124. Another front group for the Manufacturer Defendants was the
 19 American Academy of Pain Medicine (“AAPM”). With the assistance, prompting,
 20 involvement, and funding of the Manufacturer Defendants, the AAPM issued
 21 purported treatment guidelines and sponsored and hosted medical education
 22 programs essential to the Manufacturer Defendants’ deceptive marketing of
 23 chronic opioid therapy.

24
 25
 26 85 Charles Ornstein & Tracy Weber, *Senate Panel Investigates Drug Companies’*
 27 *Ties to Pain Groups*, Wash. Post, May 8, 2012,
https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU_story.html.

1 125. AAPM received substantial funding from opioid manufacturers. For
2 example, AAPM maintained a corporate relations council, whose members paid
3 \$25,000 per year (on top of other funding) to participate. The benefits included
4 allowing members to present educational programs at off-site dinner symposia in
5 connection with AAPM's marquee event – its annual meeting held in Palm
6 Springs, California, or other resort locations. AAPM describes the annual event as
7 an “exclusive venue” for offering education programs to doctors. Membership in
8 the corporate relations council also allows drug company executives and
9 marketing staff to meet with AAPM executive committee members in small
10 settings. Defendants Endo, Purdue, and Cephalon were members of the council
11 and presented deceptive programs to doctors who attended this annual event.

12 126. Upon information and belief, AAPM is viewed internally by Endo as
13 “industry friendly,” with Endo advisors and speakers among its active members.
14 Endo attended AAPM conferences, funded its CMEs, and distributed its
15 publications. The conferences sponsored by AAPM heavily emphasized sessions
16 on opioids – 37 out of roughly 40 at one conference alone. AAPM’s presidents
17 have included top industry-supported KOLs Perry Fine and Lynn Webster. Dr.
18 Webster was even elected president of AAPM while under a DEA investigation.

19 127. The Manufacturer Defendants were able to influence AAPM through
20 both their significant and regular funding and the leadership of pro-opioid KOLs
21 within the organization.

22 128. In 1996, AAPM and APS jointly issued a consensus statement, “The
23 Use of Opioids for the Treatment of Chronic Pain,” which endorsed opioids to
24 treat chronic pain and claimed that the risk of a patients’ addiction to opioids was
25 low. Dr. Haddox, who co-authored the AAPM/APS statement, was a paid speaker
26 for Purdue at the time. Dr. Portenoy was the sole consultant. The consensus
27
28

1 statement remained on AAPM's website until 2011, and, upon information and
 2 belief, was taken down from AAPM's website only after a doctor complained.⁸⁶

3 129. AAPM and APS issued their own guidelines in 2009 ("AAPM/APS
 4 Guidelines") and continued to recommend the use of opioids to treat chronic
 5 pain.⁸⁷ Treatment guidelines have been relied upon by doctors, especially the
 6 general practitioners and family doctors targeted by the Manufacturer Defendants.
 7 Treatment guidelines not only directly inform doctors' prescribing practices, but
 8 are cited throughout the scientific literature and referenced by third-party payors
 9 in determining whether they should cover treatments for specific indications.
 10 Pharmaceutical sales representatives employed by Endo, Actavis, and Purdue
 11 discussed treatment guidelines with doctors during individual sales visits.

12 130. At least fourteen of the 21 panel members who drafted the
 13 AAPM/APS Guidelines, including KOLs Dr. Portenoy and Dr. Perry Fine of the
 14 University of Utah, received support from Janssen, Cephalon, Endo, and Purdue.
 15 The 2009 Guidelines promote opioids as "safe and effective" for treating chronic
 16 pain, despite acknowledging limited evidence, and conclude that the risk of
 17 addiction is manageable for patients regardless of past abuse histories.⁸⁸ One
 18 panel member, Dr. Joel Saper, Clinical Professor of Neurology at Michigan State
 19 University and founder of the Michigan Headache & Neurological Institute,
 20 resigned from the panel because of his concerns that the 2009 Guidelines were
 21 influenced by contributions that drug companies, including Manufacturer
 22 Defendants, made to the sponsoring organizations and committee members. These
 23 AAPM/APS Guidelines have been a particularly effective channel of deception

24
 25 ⁸⁶ The Use of Opioids for the Treatment of Chronic Pain: A Consensus Statement
 26 From the American Academy of Pain Medicine and the American Pain Society, 13
 27 Clinical J. Pain 6 (1997).

28 ⁸⁷ Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in
 29 Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

⁸⁸ *Id.*

1 and have influenced not only treating physicians, but also the body of scientific
 2 evidence on opioids; the Guidelines have been cited hundreds of times in
 3 academic literature, were disseminated in the State and/or Plaintiffs' Community
 4 during the relevant time period, are still available online, and were reprinted in the
 5 Journal of Pain. The Manufacturer Defendants widely referenced and promoted
 6 the 2009 Guidelines without disclosing the lack of evidence to support them or the
 7 Manufacturer Defendants' financial support to members of the panel.

8 131. The Manufacturer Defendants worked together, through Front
 9 Groups, to spread their deceptive messages about the risks and benefits of long-
 10 term opioid therapy. For example, Defendants combined their efforts through the
 11 Pain Care Forum ("PCF"), which began in 2004 as an APF project. PCF is
 12 comprised of representatives from opioid manufacturers (including Cephalon,
 13 Endo, Janssen, and Purdue) and various Front Groups, almost all of which
 14 received substantial funding from the Manufacturer Defendants. Among other
 15 projects, PCF worked to ensure that an FDA-mandated education project on
 16 opioids was not unacceptably negative and did not require mandatory participation
 17 by prescribers, which the Manufacturer Defendants determined would reduce
 18 prescribing.

19 **2. The Manufacturer Defendants' Marketing Scheme**
 20 **Misrepresented the Risks and Benefits of Opioids.**

21 **i. The Manufacturer Defendants embarked upon a campaign**
 22 **of false, deceptive, and unfair assurances grossly**
 23 **understating and misstating the dangerous addiction risks**
 24 **of the opioid drugs.**

25 132. To falsely assure physicians and patients that opioids are safe, the
 26 Manufacturer Defendants deceptively trivialized and failed to disclose the risks of
 27 long-term opioid use, particularly the risk of addiction, through a series of
 28 misrepresentations that have been conclusively debunked by the FDA and CDC.
 These misrepresentations – which are described below – reinforced each other and
 created the dangerously misleading impression that: (1) starting patients on

1 opioids was low risk because most patients would not become addicted, and
 2 because those at greatest risk for addiction could be identified and managed; (2)
 3 patients who displayed signs of addiction probably were not addicted and, in any
 4 event, could easily be weaned from the drugs; (3) the use of higher opioid doses,
 5 which many patients need to sustain pain relief as they develop tolerance to the
 6 drugs, do not pose special risks; and (4) abuse-deterrent opioids both prevent
 7 abuse and overdose and are inherently less addictive. The Manufacturer
 8 Defendants have not only failed to correct these misrepresentations, they continue
 9 to make them today.

10 133. Opioid manufacturers, including Defendants Endo Pharmaceuticals,
 11 Inc. and Purdue Pharma L.P., have entered into settlement agreements with public
 12 entities that prohibit them from making many of the misrepresentations identified
 13 in this Complaint. Yet even afterward, each Manufacturer Defendant continued to
 14 misrepresent the risks and benefits of long-term opioid use in the State and
 15 Plaintiffs' Community and each continues to fail to correct its past
 16 misrepresentations.

17 134. Some illustrative examples of the Manufacturer Defendants' false,
 18 deceptive, and unfair claims about the purportedly low risk of addiction include:

- 19 a. Actavis's predecessor caused a patient education brochure, *Managing*
 20 *Chronic Back Pain*, to be distributed beginning in 2003 that admitted
 21 that opioid addiction is possible, but falsely claimed that it is "less
 22 likely if you have never had an addiction problem." Based on
 23 Actavis's acquisition of its predecessor's marketing materials along
 24 with the rights to Kadian, it appears that Actavis continued to use this
 25 brochure in 2009 and beyond.
- 26 b. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide*
 27 *for People Living with Pain* (2007), which suggested that addiction is
 28 rare and limited to extreme cases of unauthorized dose escalations,
 29 obtaining duplicative opioid prescriptions from multiple sources, or
 30 theft. This publication is still available online.⁸⁹

27 ⁸⁹ Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)
 28 [hereinafter APF, *Treatment Options*],
 https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf.

- c. Endo sponsored a website, “PainKnowledge,” which, upon information and belief, claimed in 2009 that “[p]eople who take opioids as prescribed usually do not become addicted.” Upon information and belief, another Endo website, PainAction.com, stated “Did you know? Most chronic pain patients do not become addicted to the opioid medications that are prescribed for them.” Endo also distributed an “Informed Consent” document on PainAction.com that misleadingly suggested that only people who “have problems with substance abuse and addiction” are likely to become addicted to opioid medications.
- d. Upon information and belief, Endo distributed a pamphlet with the Endo logo entitled *Living with Someone with Chronic Pain*, which stated that: “Most health care providers who treat people with pain agree that most people do not develop an addiction problem.”
- e. Janssen reviewed, edited, approved, and distributed a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009), which described as “myth” the claim that opioids are addictive, and asserted as fact that “[m]any studies show that opioids are rarely addictive when used properly for the management of chronic pain.”
- f. Janssen currently runs a website, Prescriberesponsibly.com (last updated July 2, 2015), which claims that concerns about opioid addiction are “overestimated.”
- g. Purdue sponsored APF’s *A Policymaker’s Guide to Understanding Pain & Its Management*, which claims that less than 1% of children prescribed opioids will become addicted and that pain is undertreated due to “[m]isconceptions about opioid addiction.”⁹⁰
- h. In 2010, Mallinckrodt sponsored an initiative “Collaborating and Acting Responsibly to Ensure Safety (C.A.R.E.S.), through which it published and promoted the book “Defeat Chronic Pain Now!” aimed at chronic pain patients. The book, which is still available for sale in New Mexico and elsewhere, and is promoted online at www.defeatchronicpainnow.com, advises laypeople who are considering taking opioid drugs that “[o]nly rarely does opioid medication cause a true addiction.”⁹¹ Further, the book advises that even the issue of tolerance is “overblown,” because “[o]nly a minority of chronic pain patients who are taking long-term opioids develop tolerance.” In response to a hypothetical question from a chronic back pain patient who expresses a fear of becoming addicted, the book advises that “[i]t is very uncommon for a person with chronic pain to become ‘addicted’ to narcotics IF (1) he doesn’t have a prior history of any addiction and (2) he only takes the medication to treat pain.”

⁹⁰ Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*], <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>.

⁹¹ Charles E. Argoff & Bradley S. Galer, *Defeat Chronic Pain Now!* (2010).

- 1 i. Consistent with the Manufacturer Defendants' published marketing
- 2 materials, upon information and belief, detailers for Purdue, Endo,
- 3 Janssen, and Cephalon in the State and Plaintiffs' Community
- 4 minimized or omitted any discussion with doctors of the risk of
- 5 addiction; misrepresented the potential for abuse of opioids with
- 6 purportedly abuse-deterrent formulations; and routinely did not
- 7 correct the misrepresentations noted above.
- 8 j. Seeking to overturn the criminal conviction of a doctor for illegally
- 9 prescribing opioids, the Manufacturer Defendants' Front Groups APF
- 10 and NFP argued in an *amicus* brief to the United States Fourth
- 11 Circuit Court of Appeals that "patients rarely become addicted to
- 12 prescribed opioids," citing research by their KOL, Dr. Portenoy.⁹²

135. These claims are contrary to longstanding scientific evidence. A 2016
 8 opioid-prescription guideline issued by the CDC (the "2016 CDC Guideline")
 9 explains that there is "[e]xtensive evidence" of the "possible harms of opioids
 10 (including opioid use disorder [an alternative term for opioid addiction], [and]
 11 overdose . . .)."⁹³ The 2016 CDC Guideline further explains that "[o]pioid pain
 12 medication use presents serious risks, including overdose and opioid use disorder"
 13 and that "continuing opioid therapy for 3 months substantially increases risk for
 14 opioid use disorder."⁹⁴

136. The FDA further exposed the falsity of Defendants' claims about the
 16 low risk of addiction when it announced changes to the labels for extended-release
 17 and long-acting ("ER/LA") opioids in 2013 and for immediate release ("IR")
 18 opioids in 2016. In its announcements, the FDA found that "most opioid drugs
 19 have 'high potential for abuse'" and that opioids "are associated with a substantial
 20 risk of misuse, abuse, NOWS [neonatal opioid withdrawal syndrome], addiction,
 21 overdose, and death." According to the FDA, because of the "known serious

24 ⁹² Brief of the American Pain Foundation, the National Pain Foundation, and the
 25 National Foundation for the Treatment of Pain in Support of Appellant and
 26 Reversal of the Conviction, *United States v. Hurowitz*, No. 05-4474 (4th Cir. Sept.
 27 8, 2005) [hereinafter Brief of APF] at 9.

28 ⁹³ Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic*
 29 *Pain—United States, 2016*, Morbidity & Mortality Wkly. Rep., Mar. 18, 2016, at
 30 15 [hereinafter 2016 CDC Guideline],
<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

31 ⁹⁴ *Id.* at 2, 25.

1 risks” associated with long-term opioid use, including “risks of addiction, abuse,
 2 and misuse, even at recommended doses, and because of the greater risks of
 3 overdose and death,” opioids should be used only “in patients for whom
 4 alternative treatment options” like non-opioid drugs have failed.⁹⁵

5 137. The State of New York, in a 2016 settlement agreement with Endo,
 6 found that opioid “use disorders appear to be highly prevalent in chronic pain
 7 patients treated with opioids, with up to 40% of chronic pain patients treated in
 8 specialty and primary care outpatient centers meeting the clinical criteria for an
 9 opioid use disorder.”⁹⁶ Endo had claimed on its www.opana.com website that
 10 “[m]ost healthcare providers who treat patients with pain agree that patients
 11 treated with prolonged opioid medicines usually do not become addicted,” but the
 12 State of New York found that Endo had no evidence for that statement. Consistent
 13 with this, Endo agreed not to “make statements that . . . opioids generally are non-
 14 addictive” or “that most patients who take opioids do not become addicted” in
 15 New York. Endo remains free, however, to make those statements in this State.

16 138. In addition to mischaracterizing the highly addictive nature of the
 17 drugs they were pushing, the Manufacturer Defendants also fostered a
 18 fundamental misunderstanding of the signs of addiction. Specifically, the
 19 Manufacturer Defendants misrepresented, to doctors and patients, that warning
 20 signs and/or symptoms of addiction were, instead, signs of undertreated pain (i.e.
 21

22 ⁹⁵ Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Evaluation and
 23 Research, U.S. Food and Drug Admin., U.S. Dep’t of Health and Human Servs., to
 24 Andrew Koldny, M.D., President, Physicians for Responsible Opioid Prescribing
 25 (Sept. 10, 2013), [https://www.regulations.gov/contentStreamer?documentId=FDA-2012-P-0818-0793&attachmentNumber=1&contentType=pdf.](https://www.regulations.gov/contentStreamer?documentId=FDA-2012-P-0818-0793&attachmentNumber=1&contentType=pdf.;); Letter from Janet
 26 Woodcock, M.D., Dir., Ctr. For Drug Evaluation and Research, U.S. Food and
 27 Drug Admin., U.S. Dep’t of Health and Human Servs., to Peter R. Mathers &
 28 Jennifer A. Davidson, Kleinfeld, Kaplan and Becker, LLP (Mar. 22, 2016),
<https://www.regulations.gov/contentStreamer?documentId=FDA-2014-P-0205-0006&attachmentNumber=1&contentType=pdf.>

96 Assurance of Discontinuance, *In re Endo Health Solutions Inc. and Endo Pharm. Inc.* (Assurance No. 15-228), at 16,
https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf.

1 pseudoaddiction) – and instructed doctors to increase the opioid prescription dose
 2 for patients who were already in danger.

3 139. To this end, one of Purdue’s employees, Dr. David Haddox, invented
 4 a phenomenon called “pseudoaddiction.” KOL Dr. Portenoy popularized the term.
 5 Examples of the false, misleading, deceptive, and unfair statements regarding
 6 pseudoaddiction include:

- 7 a. Cephalon and Purdue sponsored *Responsible Opioid Prescribing*
 8 (2007), which taught that behaviors such as “requesting drugs by
 9 name,” “demanding or manipulative behavior,” seeing more than one
 10 doctor to obtain opioids, and hoarding,⁹⁷ are all signs of
 11 pseudoaddiction, rather than true addiction.⁹⁸ The 2012 edition,
 12 which remains available for sale online, continues to teach that
 13 pseudoaddiction is real.⁹⁸
- 14 b. Janssen sponsored, funded, and edited the Let’s Talk Pain website,
 15 which in 2009 stated: “pseudoaddiction . . . refers to patient
 16 behaviors that may occur when pain is under-treated
 17 Pseudoaddiction is different from true addiction because such
 18 behaviors can be resolved with effective pain management.”
- 19 c. Endo sponsored a National Initiative on Pain Control (“NIPC”) CME
 20 program in 2009 entitled “Chronic Opioid Therapy: Understanding
 21 Risk While Maximizing Analgesia,” which, upon information and
 22 belief, promoted pseudoaddiction by teaching that a patient’s aberrant
 23 behavior was the result of untreated pain. Endo appears to have
 24 substantially controlled NIPC by funding NIPC projects; developing,
 25 specifying, and reviewing content; and distributing NIPC materials.
- 26 d. Purdue published a pamphlet in 2011 entitled *Providing Relief,*
 27 *Preventing Abuse*, which, upon information and belief, described
 28 pseudoaddiction as a concept that “emerged in the literature” to
 29 describe the inaccurate interpretation of [drug-seeking behaviors] in
 30 patients who have pain that has not been effectively treated.”
- 31 e. Upon information and belief, Purdue sponsored a CME program
 32 titled “Path of the Patient, Managing Chronic Pain in Younger Adults
 33 at Risk for Abuse”. In a role play, a chronic pain patient with a
 34 history of drug abuse tells his doctor that he is taking twice as many
 35 hydrocodone pills as directed. The narrator notes that because of
 36 pseudoaddiction, the doctor should not assume the patient is addicted
 37 even if he persistently asks for a specific drug, seems desperate,

26
 27 ⁹⁷ Scott M. Fishman, M.D., *Responsible Opioid Prescribing: A Physician’s Guide*
 28 (2d ed. 2012).

29 ⁹⁸ See Scott M. Fishman, M.D., *Responsible Opioid Prescribing: A Physician’s*
 30 *Guide* (2d ed. 2012).

1 hoards medicine, or “overindulges in unapproved escalating doses.”
 2 The doctor treats this patient by prescribing a high-dose, long-acting
 3 opioid.

4 f. In 2010, Mallinckrodt sponsored an initiative “Collaborating and
 5 Acting Responsibly to Ensure Safety (C.A.R.E.S.), through which it
 6 published and promoted the book “Defeat Chronic Pain Now!” aimed
 7 at chronic pain patients. The book, which is still available for sale,
 8 and is promoted online at www.defeatchronicpainnow.com, teaches
 9 laypeople that “pseudoaddiction” is “caused by their doctor not
 10 appropriately prescribing the opioid medication.” It teaches that
 11 “[p]seudoaddiction happens when a patient’s opioid medication is not
 12 being prescribed in doses strong enough to provide good pain relief,
 13 or if the drug is not being prescribed often enough throughout the
 14 day. . . When a pseudoaddicted patient is prescribed the proper
 15 amount of opioid medication, he or she doesn’t take any extra pills
 16 because his or her pain is relieved.”

17 140. In the 2016 CDC Guideline, the CDC rejects the validity of the
 18 pseudoaddiction fallacy invented by a Purdue employee as a reason to push more
 19 opioid drugs onto already addicted patients.

20 141. In addition to misstating the addiction risk and inventing the
 21 pseudoaddiction falsehood, a third category of false, deceptive, and unfair practice
 22 is the Manufacturer Defendants’ false instructions that addiction risk screening
 23 tools, patient contracts, urine drug screens, and similar strategies allow them to
 24 reliably identify and safely prescribe opioids to patients predisposed to addiction.
 25 These misrepresentations were especially insidious because the Manufacturer
 26 Defendants aimed them at general practitioners and family doctors who lack the
 27 time and expertise to closely manage higher-risk patients on opioids. The
 28 Manufacturer Defendants’ misrepresentations made these doctors feel more
 comfortable prescribing opioids to their patients, and patients more comfortable
 starting on opioid therapy for chronic pain. Illustrative examples include:

29 a. Endo paid for a 2007 supplement in the *Journal of Family Practice*
 30 written by a doctor who became a member of Endo’s speakers bureau
 31 in 2010. The supplement, entitled *Pain Management Dilemmas in*
32 Primary Care: Use of Opioids, emphasized the effectiveness of
 33 screening tools, claiming that patients at high risk of addiction could
 34 safely receive chronic opioid therapy using a “maximally structured
 35 approach” involving toxicology screens and pill counts.

36 b. Purdue, upon information and belief, sponsored a 2011 webinar,
 37 *Managing Patient’s Opioid Use: Balancing the Need and Risk*, which

1 claimed that screening tools, urine tests, and patient agreements
 2 prevent “overuse of prescriptions” and “overdose deaths.”
 3

4

- 5 c. As recently as 2015, upon information and belief, Purdue has
 6 represented in scientific conferences that “bad apple” patients – and
 7 not opioids – are the source of the addiction crisis and that once those
 8 “bad apples” are identified, doctors can safely prescribe opioids
 9 without causing addiction.

10 142. The 2016 CDC Guideline confirms the falsity of these claims. The
 11 Guideline explains that there are no studies assessing the effectiveness of risk
 12 mitigation strategies “for improving outcomes related to overdose, addiction,
 13 abuse or misuse.”⁹⁹

143. A fourth category of deceptive messaging regarding dangerous
 15 opioids is the Manufacturer Defendants’ false assurances regarding the alleged
 16 ease of eliminating opioid dependence. The Manufacturer Defendants falsely
 17 claimed that opioid dependence can easily be addressed by tapering and that
 18 opioid withdrawal is not a problem, but they failed to disclose the increased
 19 difficulty of stopping opioids after long-term use. In truth, the 2016 CDC
 20 Guideline explains that the symptoms of opioid withdrawal include abdominal
 21 pain, vomiting, diarrhea, sweating, tremor, tachycardia, drug cravings, anxiety,
 22 insomnia, spontaneous abortion and premature labor in pregnant women.¹⁰⁰

23 144. The Manufacturer Defendants nonetheless downplayed the severity
 24 of opioid detoxification. For example, upon information and belief, a CME
 25 sponsored by Endo, entitled *Persistent Pain in the Older Adult*, claimed that
 26 withdrawal symptoms can be avoided by tapering a patient’s opioid dose by 10%-
 27 20% for 10 days. And Purdue sponsored APF’s *A Policymaker’s Guide to*
 28 *Understanding Pain & Its Management*, which claimed that “[s]ymptoms of
 physical dependence can often be ameliorated by gradually decreasing the dose of
 medication during discontinuation” without mentioning any hardships that might

⁹⁹ *Id.* at 11.

¹⁰⁰ *Id.* at 26.

1 occur.¹⁰¹ Similarly, in the 2010 Mallinckrodt/C.A.R.E.S. publication “Defeat
 2 Chronic Pain Now!” potential opioid users are advised that tolerance to opioids is
 3 “easily remedied,” and that “[a]ll patients can be safely taken off opioid
 4 medication if the dose is slowly tapered down by their doctor.”

5 145. A fifth category of false, deceptive, and unfair statements the
 6 Manufacturer Defendants made to sell more drugs is that opioid dosages could be
 7 increased indefinitely without added risk. The ability to escalate dosages was
 8 critical to Defendants’ efforts to market opioids for long-term use to treat chronic
 9 pain because, absent this misrepresentation, doctors would have abandoned
 10 treatment when patients built up tolerance and lower dosages did not provide pain
 11 relief. The Manufacturer Defendants’ deceptive claims include:

- 12
- 13 a. Upon information and belief, Actavis’s predecessor created a patient
 brochure for Kadian in 2007 that stated, “Over time, your body may
 become tolerant of your current dose. You may require a dose
 adjustment to get the right amount of pain relief. This is not
 addiction.” Based on Actavis’s acquisition of its predecessor’s
 marketing materials along with the rights to Kadian, Actavis appears
 to have continued to use these materials in 2009 and beyond.
- 14 b. Cephalon and Purdue sponsored APF’s *Treatment Options: A Guide*
 for People Living with Pain (2007), which claims that some patients
 “need” a larger dose of an opioid, regardless of the dose currently
 prescribed. The guide stated that opioids have “no ceiling dose” and
 insinuated that they are therefore the most appropriate treatment for
 severe pain.¹⁰² This publication is still available online.
- 15 c. Endo sponsored a website, “PainKnowledge,” which, upon
 information and belief, claimed in 2009 that opioid dosages may be
 increased until “you are on the right dose of medication for your
 pain.”
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24

25 ¹⁰¹ Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its*
 Management 6 (2011) [hereinafter APF, *Policymaker’s Guide*],
<http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>, at
 32.

26

27 ¹⁰² Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)
 [hereinafter APF, *Treatment Options*],
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>, at
 12.

- d. Endo distributed a pamphlet edited by a KOL entitled *Understanding Your Pain: Taking Oral Opioid Analgesics* (2004 Endo Pharmaceuticals PM-0120). In Q&A format, it asked “If I take the opioid now, will it work later when I really need it?” The response is, “The dose can be increased. . . . You won’t ‘run out’ of pain relief.”¹⁰³
- e. Janssen sponsored a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009), which was distributed by its sales force. This guide listed dosage limitations as “disadvantages” of other pain medicines but omitted any discussion of risks of increased opioid dosages.
- f. Upon information and belief, Purdue’s In the Face of Pain website promoted the notion that if a patient’s doctor does not prescribe what, in the patient’s view, is a sufficient dosage of opioids, he or she should find another doctor who will.
- g. Purdue sponsored APF’s *A Policymaker’s Guide to Understanding Pain & Its Management*, which taught that dosage escalations are “sometimes necessary,” and that “the need for higher doses of medication is not necessarily indicative of addiction,” but inaccurately downplayed the risks from high opioid dosages.¹⁰⁴
- h. In 2007, Purdue sponsored a CME entitled “Overview of Management Options” that was available for CME credit and available until at least 2012. The CME was edited by a KOL and taught that Non-steroidal Anti-inflammatory Drugs (“NSAIDs”) and other drugs, but not opioids, are unsafe at high dosages.
- i. Purdue presented a 2015 paper at the College on the Problems of Drug Dependence, “the oldest and largest organization in the US dedicated to advancing a scientific approach to substance use and addictive disorders,” challenging the correlation between opioid dosage and overdose.¹⁰⁵
- j. Seeking to overturn the criminal conviction of a doctor for illegally prescribing opioids, the Manufacturer Defendants’ Front Groups APF and NFP argued in an *amicus* brief to the United States Fourth Circuit Court of Appeals that “there is no ‘ceiling dose’” for opioids.¹⁰⁶

¹⁰³ Margo McCaffery & Chris Pasero, Endo Pharm., *Understanding Your Pain: Taking Oral Opioid Analgesics* (Russell K Portenoy, M.D., ed., 2004).

¹⁰⁴ Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*], <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>., at 32.

¹⁰⁵ The College on Problems of Drug Dependence, *About the College*, <http://cpdd.org> (last visited Aug. 21, 2017).

¹⁰⁶ Brief of APF, at 9.

k. In the 2010 Mallinckrodt/C.A.R.E.S. publication “Defeat Chronic Pain Now!”, potential opioid users are warned about the risk of “[p]seudoaddiction [b]ecause of a [l]ow [d]ose,” and advised that this condition may be corrected through the prescription of a higher dose. Similarly, the book recommends that for chronic pain patients, the opioid dose should be “gradually increased to find the best daily dose, as is done with all the other oral drugs.” The book discusses the risks of NSAIDs and other drugs at higher doses, but not explain this risk for opioids.

146. Once again, the 2016 CDC Guideline reveals that the Manufacturer Defendants' representations regarding opioids were lacking in scientific evidence. The 2016 CDC Guideline clarifies that the “[b]enefits of high-dose opioids for chronic pain are not established” while the “risks for serious harms related to opioid therapy increase at higher opioid dosage.”¹⁰⁷ More specifically, the CDC explains that “there is now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages.”¹⁰⁸ The CDC also states that there is an increased risk “for opioid use disorder, respiratory depression, and death at higher dosages.”¹⁰⁹ That is why the CDC advises doctors to “avoid increasing dosage” to above 90 morphine milligram equivalents per day.¹¹⁰

147. Defendants' deceptive marketing of the so-called abuse-deterrent properties of some of their opioids has created false impressions that these opioids can cure addiction and abuse.

148. The Manufacturer Defendants made misleading claims about the ability of their so-called abuse-deterrent opioid formulations to deter abuse. For example, Endo’s advertisements for the 2012 reformulation of Opana ER claimed that it was designed to be crush resistant, in a way that suggested it was more difficult to abuse. This claim was false. The FDA warned in a 2013 letter that Opana ER Extended-Release Tablets’ “extended-release features can be

¹⁰⁷ 2016 CDC Guideline at 22–23.

¹⁰⁸ *Id.* at 23–24.

10^9 *Id.* at 21.

¹¹⁰ Id at 16

1 compromised, causing the medication to ‘dose dump,’ when subject to . . . forms
2 of manipulation such as cutting, grinding, or chewing, followed by
3 swallowing.”¹¹¹ Also troubling, Opana ER can be prepared for snorting using
4 commonly available methods and “readily prepared for injection.”¹¹² The letter
5 discussed “the troubling possibility that a higher (and rising) percentage of [Opana
6 ER Extended-Release Tablet] abuse is occurring via injection.”¹¹³ Endo’s own
7 studies, which it failed to disclose, showed that Opana ER could still be ground
8 and chewed. In June 2017, the FDA requested that Opana ER be removed from
9 the market.

ii. The Manufacturer Defendants embarked upon a campaign of false, deceptive, and unfair assurances grossly overstating the benefits of the opioid drugs.

12 149. To convince doctors and patients that opioids should be used to treat
13 chronic pain, the Manufacturer Defendants also had to persuade them that there
14 was a significant upside to long-term opioid use. But as the CDC Guideline makes
15 clear, “[n]o evidence shows a long-term benefit of opioids in pain and function
16 versus no opioids for chronic pain with outcomes examined at least 1 year later
17 (with most placebo-controlled randomized trials \leq 6 weeks in duration)” and that
18 other treatments were more or equally beneficial and less harmful than long-term
19 opioid use.¹¹⁴ The FDA, too, has recognized the lack of evidence to support long-
20 term opioid use. Despite this, Defendants falsely and misleadingly touted the
21 benefits of long-term opioid use and falsely and misleadingly suggested that these
22 benefits were supported by scientific evidence.

²⁵ ¹¹¹ Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Evaluation and
²⁶ Research, U.S. Food and Drug Admin., U.S. Dep’t of Health and Human Servs., to
Robert Barto, Vice President, Reg. Affairs, Endo Pharm. Inc. (May 10, 2013), at 5.

27 | ¹¹²*Id* at 6

113 *Id* at 6 n 21

28 | ¹¹⁴*Id.* at 15

1 150. Some illustrative examples of the Manufacturer Defendants' false
2 claims are:

- 3 a. Upon information and belief, Actavis distributed an advertisement
4 claiming that the use of Kadian to treat chronic pain would allow
5 patients to return to work, relieve "stress on your body and your
6 mental health," and help patients enjoy their lives.
- 7 b. Endo distributed advertisements that claimed that the use of Opana
8 ER for chronic pain would allow patients to perform demanding tasks
9 like construction work or work as a chef and portrayed seemingly
10 healthy, unimpaired subjects.
- 11 c. Janssen sponsored and edited a patient education guide entitled
12 *Finding Relief: Pain Management for Older Adults* (2009) – which
13 states as "a fact" that "opioids may make it easier for people to live
14 normally." The guide lists expected functional improvements from
15 opioid use, including sleeping through the night, returning to work,
16 recreation, sex, walking, and climbing stairs.
- 17 d. Janssen promoted Ultracet for everyday chronic pain and distributed
18 posters, for display in doctors' offices, of presumed patients in active
19 professions; the caption read, "Pain doesn't fit into their schedules."
- 20 e. Upon information and belief, Purdue ran a series of advertisements
21 for OxyContin in 2012 in medical journals entitled "Pain vignettes,"
22 which were case studies featuring patients with pain conditions
23 persisting over several months and recommending OxyContin for
24 them. The ads implied that OxyContin improves patients' function.
- 25 f. *Responsible Opioid Prescribing* (2007), sponsored and distributed by
26 Cephalon, Endo and Purdue, taught that relief of pain by opioids, by
27 itself, improved patients' function.
- 28 g. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide*
29 for *People Living with Pain* (2007), which counseled patients that
30 opioids "give [pain patients] a quality of life we deserve."¹¹⁵ This
31 publication is still available online.
- 32 h. Endo's NIPC website "PainKnowledge" claimed in 2009, upon
33 information and belief, that with opioids, "your level of function
34 should improve; you may find you are now able to participate in
35 activities of daily living, such as work and hobbies, that you were not
36 able to enjoy when your pain was worse." Elsewhere, the website
37 touted improved quality of life (as well as "improved function") as
38 benefits of opioid therapy. The grant request that Endo approved for
39 this project specifically indicated NIPC's intent to make misleading
40 claims about function, and Endo closely tracked visits to the site.

27 115 Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)
28 [hereinafter APF, *Treatment Options*],
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>.

- 1 i. Endo was the sole sponsor, through NIPC, of a series of CMEs
2 entitled “Persistent Pain in the Older Patient.”¹¹⁶ Upon information
3 and belief, a CME disseminated via webcast claimed that chronic
4 opioid therapy has been “shown to reduce pain and improve
5 depressive symptoms and cognitive functioning.”
6
- 7 j. Janssen sponsored and funded a multimedia patient education
8 campaign called “Let’s Talk Pain.” One feature of the campaign was
9 to complain that patients were under-treated. In 2009, upon
10 information and belief, a Janssen-sponsored website, part of the
11 “Let’s Talk Pain” campaign, featured an interview edited by Janssen
12 claiming that opioids allowed a patient to “continue to function.”
13
- 14 k. Purdue sponsored the development and distribution of APF’s *A
15 Policymaker’s Guide to Understanding Pain & Its Management*, which claimed that “[m]ultiple clinical studies” have shown that
16 opioids are effective in improving “[d]aily function,” “[p]sychological health,” and “[o]verall health-related quality of life
17 for chronic pain.”¹¹⁷ The Policymaker’s Guide was originally
18 published in 2011.
19
- 20 l. Purdue’s, Cephalon’s, Endo’s, and Janssen’s sales representatives
21 have conveyed and continue to convey the message that opioids will
22 improve patient function.

13 151. As the FDA and other agencies have made clear for years, these
14 claims have no support in the scientific literature.

15 152. In 2010, the FDA warned Actavis, in response to its advertising of
16 Kadian described above, that “we are not aware of substantial evidence or
17 substantial clinical experience demonstrating that the magnitude of the effect of
18 the drug [Kadian] has in alleviating pain, taken together with any drug-related side
19 effects patients may experience . . . results in any overall positive impact on a
20 patient’s work, physical and mental functioning, daily activities, or enjoyment of
21 life.”¹¹⁸ And in 2008, upon information and belief, the FDA sent a warning letter
22

23

24 ¹¹⁶ E.g., NIPC, *Persistent Pain and the Older Patient* (2007),
25 https://www.painedu.org/Downloads/NIPC/Activities/B173_Providence_RI_%20Invite.pdf.

26 ¹¹⁷ Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its
27 Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*],
28 <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>., at
29.

118 Letter from Thomas Abrams, Dir., Div. of Drug Mktg., Advert., & Commc’ns,
U.S. Food & Drug Admin., to Doug Boothe, CEO, Actavis Elizabeth LLC (Feb.

1 to an opioid manufacturer, making it clear “that [the claim that] patients who are
2 treated with the drug experience an improvement in their overall function, social
3 function, and ability to perform daily activities . . . has not been demonstrated by
4 substantial evidence or substantial clinical experience.”

5 153. The Manufacturer Defendants also falsely and misleadingly
6 emphasized or exaggerated the risks of competing medications like NSAIDs, so
7 that doctors and patients would look to opioids first for the treatment of chronic
8 pain. Once again, these misrepresentations by the Manufacturer Defendants
9 contravene pronouncements by and guidance from the FDA and CDC based on
10 the scientific evidence. Indeed, the FDA changed the labels for extended-release
11 and long-acting (“ER/LA”) opioids in 2013 and immediate-release (“IR”) opioids
12 in 2016 to state that opioids should only be used as a last resort “in patients for
13 which alternative treatment options” like non-opioid drugs “are inadequate.” And
14 the 2016 CDC Guideline states that NSAIDs, not opioids, should be the first-line
15 treatment for chronic pain, particularly arthritis and lower back pain.¹¹⁹ Purdue
16 misleadingly promoted OxyContin as being unique among opioids in providing 12
17 continuous hours of pain relief with one dose. In fact, OxyContin does not last for
18 12 hours – a fact that Purdue has known at all times relevant to this action. Upon
19 information and belief, Purdue’s own research shows that OxyContin wears off in
20 under six hours in one quarter of patients and in under 10 hours in more than half.
21 This is because OxyContin tablets release approximately 40% of their active
22 medicine immediately, after which release tapers. This triggers a powerful initial
23 response, but provides little or no pain relief at the end of the dosing period, when
24 less medicine is released. This phenomenon is known as “end of dose” failure, and
25 the FDA found in 2008 that a “substantial proportion” of chronic pain patients

²⁷ 18, 2010),
²⁸ <http://www.fdanews.com/ext/resources/files/archives/a/ActavisElizabethLLC.pdf>.
¹¹⁹ 2016 CDC Guideline at 12.

1 taking OxyContin experience it. This not only renders Purdue's promise of 12
 2 hours of relief false and deceptive, it also makes OxyContin more dangerous
 3 because the declining pain relief patients experience toward the end of each
 4 dosing period drives them to take more OxyContin before the next dosing period
 5 begins, quickly increasing the amount of drug they are taking and spurring
 6 growing dependence.

7 154. Purdue's competitors were aware of this problem. For example, upon
 8 information and belief, Endo ran advertisements for Opana ER referring to "real"
 9 12-hour dosing. Nevertheless, Purdue falsely promoted OxyContin as if it were
 10 effective for a full 12 hours. Upon information and belief, Purdue's sales
 11 representatives continue to tell doctors that OxyContin lasts a full 12 hours.

12 155. Front Groups supported by Purdue likewise echoed these
 13 representations. For example, in an amicus brief submitted to the Supreme Court
 14 of Ohio by the American Pain Foundation, the National Foundation for the
 15 Treatment of Pain and the Ohio Pain Initiative in support of Purdue, those amici
 16 represented:

17 OxyContin is particularly useful for sustained long-term pain because
 18 it comes in higher, compact pills with a slow release coating. OxyContin pills can work for 12 hours. This makes it easier for
 19 patients to comply with dosing requirements without experiencing a roller-coaster of pain relief followed quickly by pain renewal that can
 20 occur with shorter acting medications. It also helps the patient sleep
 21 through the night, which is often impossible with short-acting
 22 medications. For many of those serviced by Pain Care Amici,¹²⁰ OxyContin has been a miracle medication.

23 156. Cephalon deceptively marketed its opioids Actiq and Fentora for
 24 chronic pain even though the FDA has expressly limited their use to the treatment
 25 of cancer pain in opioid tolerant individuals. Both Actiq and Fentora are

26
 27 ¹²⁰ Reply Brief of Amicus Curiae of the American Pain Foundation, The National
 28 Foundation for the Treatment of Pain and the Ohio Pain Initiative Supporting
 Appellants, *Howland v. Purdue Pharma L.P.*, No. 2003-1538 (Ohio Apr. 13,
 2004), 2004 WL 1637768, at *4 (footnote omitted).

1 extremely powerful fentanyl-based IR opioids. Neither is approved for or has been
 2 shown to be safe or effective for chronic pain. Indeed, the FDA expressly
 3 prohibited Cephalon from marketing Actiq for anything but cancer pain, and
 4 refused to approve Fentora for the treatment of chronic pain because of the
 5 potential harm, including the high risk of “serious and life-threatening adverse
 6 events” and abuse – which are greatest in non-cancer patients. The FDA also
 7 issued a Public Health Advisory in 2007 emphasizing that Fentora should only be
 8 used for cancer patients who are opioid-tolerant and should not be used for any
 9 other conditions, such as migraines, post-operative pain, or pain due to injury.¹²¹
 10 Specifically, the FDA advised that Fentora “is only approved for breakthrough
 11 cancer pain in patients who are *opioid-tolerant*, meaning those patients who take a
 12 regular, daily, around-the-clock narcotic pain medication.”¹²²

13 157. Despite this, Cephalon conducted and continues to conduct a well-
 14 funded campaign to promote Actiq and Fentora for chronic pain and other non-
 15 cancer conditions for which it was not approved, appropriate, and for which it is
 16 not safe. As part of this campaign, Cephalon used CMEs, speaker programs,
 17 KOLs, journal supplements, and detailing by its sales representatives to give
 18 doctors the false impression that Actiq and Fentora are safe and effective for
 19 treating non-cancer pain. For example:

- 20 a. Cephalon paid to have a CME it sponsored, *Opioid-Based*
 Management of Persistent and Breakthrough Pain, published in a
 supplement of Pain Medicine News in 2009. The CME instructed
 doctors that “[c]linically, broad classification of pain syndromes as
 either cancer- or non-cancer-related has limited utility” and
 recommended Actiq and Fentora for patients with chronic pain.
- 24 b. Upon information and belief, Cephalon’s sales representatives set up
 hundreds of speaker programs for doctors, including many non-

26 ¹²¹ See U.S. Food & Drug Admin., *Public Health Advisory: Important Information*
 27 *for the Safe Use of Fentora (fentanyl buccal tablets)* (Sept. 26, 2007),
 28 <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm051273.htm>.

122 ^{Id.}

1 oncologists, which promoted Actiq and Fentora for the treatment of
 2 non-cancer pain.

3

4 c. In December 2011, Cephalon widely disseminated a journal
 5 supplement entitled “Special Report: An Integrated Risk Evaluation
 6 and Mitigation Strategy for Fentanyl Buccal Tablet (FENTORA) and
 7 Oral Transmucosal Fentanyl Citrate (ACTIQ)” to Anesthesiology
 8 News, Clinical Oncology News, and Pain Medicine News – three
 9 publications that are sent to thousands of anesthesiologists and other
 10 medical professionals. The Special Report openly promotes Fentora
 11 for “multiple causes of pain” – and not just cancer pain.

12

13 158. Cephalon’s deceptive marketing gave doctors and patients the false
 14 impression that Actiq and Fentora were not only safe and effective for treating
 15 chronic pain, but were also approved by the FDA for such uses.

16

17 159. Purdue also unlawfully and unfairly failed to report or address illicit
 18 and unlawful prescribing of its drugs, despite knowing about it for years. Purdue’s
 19 sales representatives have maintained a database since 2002 of doctors suspected
 20 of inappropriately prescribing its drugs. Rather than report these doctors to state
 21 medical boards or law enforcement authorities (as Purdue is legally obligated to
 22 do) or cease marketing to them, Purdue used the list to demonstrate the high rate
 23 of diversion of OxyContin – the same OxyContin that Purdue had promoted as
 24 less addictive – in order to persuade the FDA to bar the manufacture and sale of
 25 generic copies of the drug because the drug was too likely to be abused. In an
 26 interview with the Los Angeles Times, Purdue’s senior compliance officer
 27 acknowledged that in five years of investigating suspicious pharmacies, Purdue
 28 failed to take action – even where Purdue employees personally witnessed the
 diversion of its drugs. The same was true of prescribers; despite its knowledge of
 illegal prescribing, Purdue did not report that a Los Angeles clinic prescribed
 more than 1.1 million OxyContin tablets and that Purdue’s district manager
 described it internally as “an organized drug ring” until years after law

1 enforcement shut it down. In doing so, Purdue protected its own profits at the
2 expense of public health and safety.¹²³

3 160. Like Purdue, Endo has been cited for its failure to set up an effective
4 system for identifying and reporting suspicious prescribing. In its settlement
5 agreement with Endo, the State of New York found that Endo failed to require
6 sales representatives to report signs of abuse, diversion, and inappropriate
7 prescribing; paid bonuses to sales representatives for detailing prescribers who
8 were subsequently arrested or convicted for illegal prescribing; and failed to
9 prevent sales representatives from visiting prescribers whose suspicious conduct
10 had caused them to be placed on a no-call list.

11 **3. The Manufacturer Defendants Targeted Susceptible Prescribers
12 and Vulnerable Patient Populations.**

13 161. As a part of their deceptive marketing scheme, the Manufacturer
14 Defendants identified and targeted susceptible prescribers and vulnerable patient
15 populations in the U.S., including this State and Plaintiffs' Community. For
16 example, the Manufacturer Defendants focused their deceptive marketing on
17 primary care doctors, who were more likely to treat chronic pain patients and
18 prescribe them drugs, but were less likely to be educated about treating pain and
19 the risks and benefits of opioids and therefore more likely to accept the
20 Manufacturer Defendants' misrepresentations.

21 162. The Manufacturer Defendants also targeted vulnerable patient
22 populations like the elderly and veterans, who tend to suffer from chronic pain.
23 The Manufacturer Defendants targeted these vulnerable patients even though the
24 risks of long-term opioid use were significantly greater for them. For example, the
25 2016 CDC Guideline observes that existing evidence confirms that elderly
26

27

28 ¹²³ Harriet Ryan et al., *More Than 1 Million Oxycontin Pills Ended Up in the
Hands of Criminals and Addicts. What the Drugmaker Knew*, L.A. Times, July 10,
2016, <http://www.latimes.com/projects/la-me-oxycontin-part2/>.

1 patients taking opioids suffer from elevated fall and fracture risks, reduced renal
2 function and medication clearance, and a smaller window between safe and unsafe
3 dosages.¹²⁴ The 2016 CDC Guideline concludes that there must be “additional
4 caution and increased monitoring” to minimize the risks of opioid use in elderly
5 patients. *Id.* at 27. The same is true for veterans, who are more likely to use anti-
6 anxiety drugs (benzodiazepines) for post-traumatic stress disorder, which interact
7 dangerously with opioids.

4. Insys Employed Fraudulent, Illegal, and Misleading Marketing Schemes to Promote Subsys.

163. Insys's opioid, Subsys, was approved by the FDA in 2012 for
“management of breakthrough pain in adult cancer patients who are already
receiving and who are tolerant to around-the-clock opioid therapy for their
underlying persistent cancer pain.” Under FDA rules, Insys could only market
Subsys for this use. Subsys consists of the highly addictive narcotic, fentanyl,
administered via a sublingual (under the tongue) spray, which provides rapid-
onset pain relief. It is in the class of drugs described as Transmucosal Immediate-
Release Fentanyl (“TIRF”).

18 164. To reduce the risk of abuse, misuse, and diversion, the FDA
19 instituted a Risk Evaluation and Mitigation Strategy (“REMS”) for Subsys and
20 other TIRF products, such as Cephalon’s Actiq and Fentora. The purpose of
21 REMS was to educate “prescribers, pharmacists, and patients on the potential for
22 misuse, abuse, addiction, and overdose” for this type of drug and to “ensure safe
23 use and access to these drugs for patients who need them.”¹²⁵ Prescribers must
24 enroll in the TIRF REMS before writing a prescription for Subsys.

²⁷ ¹²⁴ 2016 CDC Guideline at 13.

²⁸ ¹²⁵ Press Release, FDA, *FDA Approves Shared System REMS for TIRF Products*, Dec. 29, 2011.

1 165. Since its launch, Subsys has been an extremely expensive
2 medication, and its price continues to rise each year. Depending on a patient's
3 dosage and frequency of use, a month's supply of Subsys could cost in the
4 thousands of dollars.

5 166. Due to its high cost, in most instances prescribers must submit
6 Subsys prescriptions to insurance companies or health benefit payors for prior
7 authorization to determine whether they will pay for the drug prior to the patient
8 attempting to fill the prescription. According to the U.S. Senate Homeland
9 Security and Governmental Affairs Committee Minority Staff Report ("Staff
10 Report"), the prior authorization process includes "confirmation that the patient
11 had an active cancer diagnosis, was being treated by an opioid (and, thus, was
12 opioid tolerant), and was being prescribed Subsys to treat breakthrough pain that
13 the other opioid could not eliminate. If any one of these factors was not present,
14 the prior authorization would be denied . . ." ¹²⁶

15 167. These prior authorization requirements proved to be daunting.
16 Subsys received reimbursement approval in only approximately 30% of submitted
17 claims. In order to increase approvals, Insys created a prior authorization unit,
18 called the Insys Reimbursement Center ("IRC"), to obtain approval for Subsys
19 reimbursements. This unit employed a number of fraudulent and misleading
20 tactics to secure reimbursements, including falsifying medical histories of
21 patients, falsely claiming that patients had cancer, and providing misleading
22 information to insurers and payors regarding patients' diagnoses and medical
23 conditions.

24
25
26
27

¹²⁶ U.S. Senate Homeland Security & Governmental Affairs Committee, *Fueling*
28 *an Epidemic, Insys Therapeutics and the Systemic Manipulation of Prior*
 Authorization, <https://www.documentcloud.org/documents/3987564-REPORT-Fueling-an-Epidemic-Insys-Therapeutics.html>.

1 168. Subsys has proved to be extremely profitable for Insys. Insys made
 2 approximately \$330 million in net revenue from Subsys last year. Between 2013
 3 and 2016, the value of Insys stock rose 296%.

4 169. Since its launch in 2012, Insys aggressively worked to grow its
 5 profits through fraudulent, illegal, and misleading tactics, including its
 6 reimbursement-related fraud. Through its sales representatives and other
 7 marketing efforts, Insys deceptively promoted Subsys as safe and appropriate for
 8 uses such as neck and back pain, without disclosing the lack of approval or
 9 evidence for such uses, and misrepresented the appropriateness of Subsys for
 10 treatment those conditions. It implemented a kickback scheme wherein it paid
 11 prescribers for fake speakers programs in exchange for prescribing Subsys. All of
 12 these fraudulent and misleading schemes had the effect of pushing Insys's
 13 dangerous opioid onto patients who did not need it.

14 170. Insys incentivized its sales force to engage in illegal and fraudulent
 15 conduct. Many of the Insys sales representatives were new to the pharmaceutical
 16 industry and their base salaries were low compared to industry standard. The
 17 compensation structure was heavily weighted toward commissions and rewarded
 18 reps more for selling higher (and more expensive) doses of Subsys, a "highly
 19 unusual" practice because most companies consider dosing a patient-specific
 20 decision that should be made by a doctor.¹²⁷

21 171. The Insys "speakers program" was perhaps its most widespread and
 22 damaging scheme. A former Insys salesman, Ray Furchak, alleged in a qui tam
 23 action that the sole purpose of the speakers program was "in the words of his then
 24 supervisor Alec Burlakoff, 'to get money in the doctor's pocket.'" Furchak went
 25 on to explain that "[t]he catch . . . was that doctors who increased the level of
 26 Subsys prescriptions, and at higher dosages (such as 400 or 800 micrograms

27
 28

¹²⁷ *Id.*

1 instead of 200 micrograms), would receive the invitations to the program—and
 2 the checks.”¹²⁸ It was a pay-to-prescribe program.

3 172. Insys’s sham speaker program and other fraudulent and illegal tactics
 4 have been outlined in great detail in indictments and guilty pleas of Insys
 5 executives, employees, and prescribers across the country, as well as in a number
 6 of lawsuits against the company itself.

7 173. In May of 2015, two Alabama pain specialists were arrested and
 8 charged with illegal prescription drug distribution, among other charges. The
 9 doctors were the top prescribers of Subsys, though neither were oncologists.
 10 According to prosecutors, the doctors received illegal kickbacks from Insys for
 11 prescribing Subsys. Both doctors had prescribed Subsys to treat neck, back, and
 12 joint pain. In February of 2016, a former Insys sales manager pled guilty to
 13 conspiracy to commit health care fraud, including engaging in a kickback scheme
 14 in order to induce one of these doctors to prescribe Subsys. The plea agreement
 15 states that nearly all of the Subsys prescriptions written by the doctor were off-
 16 label to non-cancer patients. In May of 2017, one of the doctors was sentenced to
 17 20 years in prison.

18 174. In June of 2015, a nurse practitioner in Connecticut described as the
 19 state’s highest Medicare prescriber of narcotics, pled guilty to receiving \$83,000
 20 in kickbacks from Insys for prescribing Subsys. Most of her patients were
 21 prescribed the drug for chronic pain. Insys paid the nurse as a speaker for more
 22 than 70 dinner programs at approximately \$1,000 per event; however, she did not
 23 give any presentations. In her guilty plea, the nurse admitted receiving the
 24 speaker fees in exchange for writing prescriptions for Subsys.

25 175. In August of 2015, Insys settled a complaint brought by the Oregon
 26 Attorney General. In its complaint, the Oregon Department of Justice cited Insys

28 ¹²⁸ Roddy Boyd, *Insys Therapeutics and the New ‘Killing It’”*, Southern
 Investigative Reporting Foundation, The Investigator, April 24, 2015.

1 for, among other things, misrepresenting to doctors that Subsys could be used to
 2 treat migraine, neck pain, back pain, and other uses for which Subsys is neither
 3 safe nor effective, and using speaking fees as kickbacks to incentivize doctors to
 4 prescribe Subsys.

5 176. In August of 2016, the State of Illinois sued Insys for similar
 6 deceptive and illegal practices. The Complaint alleged that Insys marketed
 7 Subsys to high-volume prescribers of opioid drugs instead of to oncologists whose
 8 patients experienced the breakthrough cancer pain for which the drug is indicated.
 9 The Illinois Complaint also details how Insys used its speaker program to pay
 10 high volume prescribers to prescribe Subsys. The speaker events took place at
 11 upscale restaurants in the Chicago area, and Illinois speakers received an
 12 “honorarium” ranging from \$700 to \$5,100, and they were allowed to order as
 13 much food and alcohol as they wanted. At most of the events, the “speaker” being
 14 paid by Insys did not speak, and, on many occasions, the only attendees at the
 15 events were the speaker and an Insys sales representative.

16 177. In December of 2016, six Insys executives and managers were
 17 indicted and then, in October 2017, Insys’s founder and owner was arrested and
 18 charged with multiple felonies in connection with an alleged conspiracy to bribe
 19 practitioners to prescribe Subsys and defraud insurance companies. A U.S.
 20 Department of Justice press release explained that, among other things: “Insys
 21 executives improperly influenced health care providers to prescribe a powerful
 22 opioid for patients who did not need it, and without complying with FDA
 23 requirements, thus putting patients at risk and contributing to the current opioid
 24 crisis.”¹²⁹ A Drug Enforcement Administration (“DEA”) Special Agent in Charge
 25 further explained that: “Pharmaceutical companies whose products include

27 28 ¹²⁹ Press Release, DOJ, U.S. Attorney’s Office, Dist. of Mass., *Founder and Owner*
of Pharmaceutical Company Insys Arrested and Charged with Racketeering (Oct.
 26, 2017), available at <https://www.justice.gov/usao-ma/pr/insys-arrested-and-charged-racketeering>.

1 controlled medications that can lead to addiction and overdose have a special
2 obligation to operate in a trustworthy, transparent manner, because their
3 customers' health and safety and, indeed, very lives depend on it.”¹³⁰

4 **5. The Manufacturer Defendants made Materially Deceptive
5 Statements and Concealed Material Facts.**

6 178. As alleged herein, the Manufacturer Defendants made and/or
7 disseminated deceptive statements regarding material facts and further concealed
8 material facts, in the course of manufacturing, marketing, and selling prescription
9 opioids. The Manufacturer Defendants’ actions were intentional and/or unlawful.
10 Such statements include, but are not limited to, those set out below and alleged
11 throughout this Complaint.

12 179. Defendant Purdue made and/or disseminated deceptive statements,
13 and concealed material facts in such a way to make their statements deceptive,
14 including, but not limited to, the following:

- 15 a. Creating, sponsoring, and assisting in the distribution of patient
16 education materials distributed to consumers that contained deceptive
statements;
- 17 b. Creating and disseminating advertisements that contained deceptive
18 statements concerning the ability of opioids to improve function
long-term and concerning the evidence supporting the efficacy of
19 opioids long-term for the treatment of chronic non-cancer pain;
- 20 c. Disseminating misleading statements concealing the true risk of
addiction and promoting the deceptive concept of pseudoaddiction
21 through Purdue’s own unbranded publications and on internet sites
Purdue operated that were marketed to and accessible by consumers;
- 22 d. Distributing brochures to doctors, patients, and law enforcement
23 officials that included deceptive statements concerning the indicators
of possible opioid abuse;
- 24 e. Sponsoring, directly distributing, and assisting in the distribution of
25 publications that promoted the deceptive concept of pseudoaddiction,
even for high-risk patients;

26
27
28

¹³⁰ *Id.*

- f. Endorsing, directly distributing, and assisting in the distribution of publications that presented an unbalanced treatment of the long-term and dose-dependent risks of opioids versus NSAIDs;
- g. Providing significant financial support to pro-opioid KOL doctors who made deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- h. Providing needed financial support to pro-opioid pain organizations that made deceptive statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain;
- i. Assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction;
- j. Endorsing and assisting in the distribution of CMEs containing deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- k. Developing and disseminating scientific studies that misleadingly concluded opioids are safe and effective for the long-term treatment of chronic non-cancer pain and that opioids improve quality of life, while concealing contrary data;
- l. Assisting in the dissemination of literature written by pro-opioid KOLs that contained deceptive statements concerning the use of opioids to treat chronic noncancer pain;
- m. Creating, endorsing, and supporting the distribution of patient and prescriber education materials that misrepresented the data regarding the safety and efficacy of opioids for the long-term treatment of chronic non-cancer pain, including known rates of abuse and addiction and the lack of validation for long-term efficacy;
- n. Targeting veterans by sponsoring and disseminating patient education marketing materials that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- o. Targeting the elderly by assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction in this population;
- p. Exclusively disseminating misleading statements in education materials to hospital doctors and staff while purportedly educating them on new pain standards;
- q. Making deceptive statements concerning the use of opioids to treat chronic noncancer pain to prescribers through in-person detailing; and
- r. Withholding from law enforcement the names of prescribers Purdue believed to be facilitating the diversion of its opioid, while simultaneously marketing opioids to these doctors by disseminating

1 patient and prescriber education materials and advertisements and
 2 CMEs they knew would reach these same prescribers.

3 180. Defendant Endo made and/or disseminated deceptive statements, and
 4 concealed material facts in such a way to make their statements deceptive,
 including, but not limited to, the following:

- 5 a. Creating, sponsoring, and assisting in the distribution of patient
 education materials that contained deceptive statements;
- 6 b. Creating and disseminating advertisements that contained deceptive
 statements concerning the ability of opioids to improve function
 long-term and concerning the evidence supporting the efficacy of
 opioids long-term for the treatment of chronic non-cancer pain;
- 7 c. Creating and disseminating paid advertisement supplements in
 academic journals promoting chronic opioid therapy as safe and
 effective for long term use for high risk patients;
- 8 d. Creating and disseminating advertisements that falsely and
 inaccurately conveyed the impression that Endo's opioids would
 provide a reduction in oral, intranasal, or intravenous abuse;
- 9 e. Disseminating misleading statements concealing the true risk of
 addiction and promoting the misleading concept of pseudoaddiction
 through Endo's own unbranded publications and on internet sites
 Endo sponsored or operated;
- 10 f. Endorsing, directly distributing, and assisting in the distribution of
 publications that presented an unbalanced treatment of the long-term
 and dose-dependent risks of opioids versus NSAIDs;
- 11 g. Providing significant financial support to pro-opioid KOLs, who
 made deceptive statements concerning the use of opioids to treat
 chronic non-cancer pain;
- 12 h. Providing needed financial support to pro-opioid pain organizations –
 including over \$5 million to the organization responsible for many of
 the most egregious misrepresentations – that made deceptive
 statements, including in patient education materials, concerning the
 use of opioids to treat chronic non-cancer pain;
- 13 i. Targeting the elderly by assisting in the distribution of guidelines that
 contained deceptive statements concerning the use of opioids to treat
 chronic non-cancer pain and misrepresented the risks of opioid
 addiction in this population;
- 14 j. Endorsing and assisting in the distribution of CMEs containing
 deceptive statements concerning the use of opioids to treat chronic
 non-cancer pain;
- 15 k. Developing and disseminating scientific studies that deceptively
 concluded opioids are safe and effective for the long-term treatment
 of chronic non-cancer pain and that opioids improve quality of life,
 while concealing contrary data;

1. Directly distributing and assisting in the dissemination of literature written by pro-opioid KOLs that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain, including the concept of pseudoaddiction;
- m. Creating, endorsing, and supporting the distribution of patient and prescriber education materials that misrepresented the data regarding the safety and efficacy of opioids for the long-term treatment of chronic non-cancer pain, including known rates of abuse and addiction and the lack of validation for long-term efficacy; and
- n. Making deceptive statements concerning the use of opioids to treat chronic non-cancer pain to prescribers through in-person detailing.

181. Defendant Janssen made and/or disseminated deceptive statements, and concealed material facts in such a way to make their statements deceptive, including, but not limited to, the following:

- a. Creating, sponsoring, and assisting in the distribution of patient education materials that contained deceptive statements;
- b. Directly disseminating deceptive statements through internet sites over which Janssen exercised final editorial control and approval stating that opioids are safe and effective for the long-term treatment of chronic non-cancer pain and that opioids improve quality of life, while concealing contrary data;
- c. Disseminating deceptive statements concealing the true risk of addiction and promoting the deceptive concept of pseudoaddiction through internet sites over which Janssen exercised final editorial control and approval;
- d. Promoting opioids for the treatment of conditions for which Janssen knew, due to the scientific studies it conducted, that opioids were not efficacious and concealing this information;
- e. Sponsoring, directly distributing, and assisting in the dissemination of patient education publications over which Janssen exercised final editorial control and approval, which presented an unbalanced treatment of the long-term and dose dependent risks of opioids versus NSAIDs;
- f. Providing significant financial support to pro-opioid KOLs, who made deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- g. Providing necessary financial support to pro-opioid pain organizations that made deceptive statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain;
- h. Targeting the elderly by assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction in this population;

- 1 i. Targeting the elderly by sponsoring, directly distributing, and
2 assisting in the dissemination of patient education publications
3 targeting this population that contained deceptive statements about
4 the risks of addiction and the adverse effects of opioids, and made
5 false statements that opioids are safe and effective for the long-term
6 treatment of chronic non-cancer pain and improve quality of life,
7 while concealing contrary data;
- 8 j. Endorsing and assisting in the distribution of CMEs containing
9 deceptive statements concerning the use of opioids to treat chronic
10 non-cancer pain;
- 11 k. Directly distributing and assisting in the dissemination of literature
12 written by pro-opioid KOLs that contained deceptive statements
13 concerning the use of opioids to treat chronic non-cancer pain,
14 including the concept of pseudoaddiction;
- 15 l. Creating, endorsing, and supporting the distribution of patient and
16 prescriber education materials that misrepresented the data regarding
17 the safety and efficacy of opioids for the long-term treatment of
18 chronic non-cancer pain, including known rates of abuse and
19 addiction and the lack of validation for long-term efficacy;
- 20 m. Targeting veterans by sponsoring and disseminating patient
21 education marketing materials that contained deceptive statements
22 concerning the use of opioids to treat chronic non-cancer pain; and
- 23 n. Making deceptive statements concerning the use of opioids to treat
24 chronic non-cancer pain to prescribers through in-person detailing.

182. Defendant Cephalon made and/or disseminated untrue, false and
19 deceptive statements, and concealed material facts in such a way to make their
20 statements deceptive, including, but not limited to, the following:

- 21 a. Creating, sponsoring, and assisting in the distribution of patient
22 education materials that contained deceptive statements;
- 23 b. Sponsoring and assisting in the distribution of publications that
24 promoted the deceptive concept of pseudoaddiction, even for high-
25 risk patients;
- 26 c. Providing significant financial support to pro-opioid KOL doctors
27 who made deceptive statements concerning the use of opioids to treat
28 chronic non-cancer pain and breakthrough chronic non-cancer pain;
- 29 d. Developing and disseminating scientific studies that deceptively
30 concluded opioids are safe and effective for the long-term treatment
31 of chronic non-cancer pain in conjunction with Cephalon's potent
32 rapid-onset opioids;
- 33 e. Providing needed financial support to pro-opioid pain organizations
34 that made deceptive statements, including in patient education
35 materials, concerning the use of opioids to treat chronic non-cancer
36 pain;

- 1 f. Endorsing and assisting in the distribution of CMEs containing
2 deceptive statements concerning the use of opioids to treat chronic
3 non-cancer pain;
- 4 g. Endorsing and assisting in the distribution of CMEs containing
5 deceptive statements concerning the use of Cephalon's rapid-onset
6 opioids;
- 7 h. Directing its marketing of Cephalon's rapid-onset opioids to a wide
8 range of doctors, including general practitioners, neurologists, sports
9 medicine specialists, and workers' compensation programs, serving
10 chronic pain patients;
- 11 i. Making deceptive statements concerning the use of Cephalon's
12 opioids to treat chronic non-cancer pain to prescribers through in-
13 person detailing and speakers' bureau events, when such uses are
14 unapproved and unsafe; and
- 15 j. Making deceptive statements concerning the use of opioids to treat
16 chronic non-cancer pain to prescribers through in-person detailing
17 and speakers' bureau events.

183. Defendant Actavis made and/or disseminated deceptive statements,
19 and concealed material facts in such a way to make their statements deceptive,
20 including, but not limited to, the following:

- 21 a. Making deceptive statements concerning the use of opioids to treat
22 chronic non-cancer pain to prescribers through in-person detailing;
- 23 b. Creating and disseminating advertisements that contained deceptive
24 statements that opioids are safe and effective for the long-term
25 treatment of chronic non-cancer pain and that opioids improve
26 quality of life;
- 27 c. Creating and disseminating advertisements that concealed the risk of
28 addiction in the long-term treatment of chronic, non-cancer pain; and
- d. Developing and disseminating scientific studies that deceptively
concluded opioids are safe and effective for the long-term treatment
of chronic non-cancer pain and that opioids improve quality of life
while concealing contrary data.

6. The Manufacturer Defendants Fraudulently Concealed Their Misconduct.

184. The Manufacturer Defendants, both individually and collectively,
made, promoted, and profited from their misrepresentations about the risks and
benefits of opioids for chronic pain even though they knew that their
misrepresentations were false and deceptive. The history of opioids, as well as
research and clinical experience establish that opioids are highly addictive and are

1 responsible for a long list of very serious adverse outcomes. The FDA warned
2 Defendants of this, and Defendants had access to scientific studies, detailed
3 prescription data, and reports of adverse events, including reports of addiction,
4 hospitalization, and death – all of which clearly described the harm from long-
5 term opioid use and that patients were suffering from addiction, overdose, and
6 death in alarming numbers. More recently, the FDA and CDC have issued
7 pronouncements, based on medical evidence, that conclusively expose the falsity
8 of Defendants' misrepresentations, and Endo and Purdue have recently entered
9 into agreements in New York prohibiting them from making some of the same
10 misrepresentations described in this Complaint.

11 185. At all times relevant to this Complaint, the Manufacturer Defendants
12 took steps to avoid detection of and to fraudulently conceal their deceptive
13 marketing and unlawful, unfair, and fraudulent conduct. For example, the
14 Manufacturer Defendants disguised their role in the deceptive marketing of
15 chronic opioid therapy by funding and working through third parties like Front
16 Groups and KOLs. The Manufacturer Defendants purposefully hid behind the
17 assumed credibility of these individuals and organizations and relied on them to
18 vouch for the accuracy and integrity of the Manufacturer Defendants' false and
19 deceptive statements about the risks and benefits of long-term opioid use for
20 chronic pain. Defendants also never disclosed their role in shaping, editing, and
21 approving the content of information and materials disseminated by these third
22 parties. The Manufacturer Defendants exerted considerable influence on these
23 promotional and "educational" materials in emails, correspondence, and meetings
24 with KOLs, Front Groups, and public relations companies that were not, and have
25 not yet become, public. For example, PainKnowledge.org, which is run by the
26 NIPC, did not disclose Endo's involvement. Other Manufacturer Defendants, such
27 as Purdue and Janssen, ran similar websites that masked their own role.
28

1 186. Finally, the Manufacturer Defendants manipulated their promotional
2 materials and the scientific literature to make it appear that these documents were
3 accurate, truthful, and supported by objective evidence when they were not. The
4 Manufacturer Defendants distorted the meaning or import of studies they cited
5 and offered them as evidence for propositions the studies did not support. The
6 Manufacturer Defendants invented “pseudoaddiction” and promoted it to an
7 unsuspecting medical community. The Manufacturer Defendants provided the
8 medical community with false and misleading information about ineffectual
9 strategies to avoid or control opioid addiction. The Manufacturer Defendants
10 recommended to the medical community that dosages be increased, without
11 disclosing the risks. The Manufacturer Defendants spent millions of dollars over a
12 period of years on a misinformation campaign aimed at highlighting opioids’
13 alleged benefits, disguising the risks, and promoting sales. The lack of support for
14 the Manufacturer Defendants’ deceptive messages was not apparent to medical
15 professionals who relied upon them in making treatment decisions, nor could it
16 have been detected by the Plaintiffs or Plaintiffs’ Community. Thus, the
17 Manufacturer Defendants successfully concealed from the medical community,
18 patients, and health care payors facts sufficient to arouse suspicion of the claims
19 that the Plaintiffs now assert. Plaintiffs did not know of the existence or scope of
20 the Manufacturer Defendants’ industry-wide fraud and could not have acquired
21 such knowledge earlier through the exercise of reasonable diligence.

22 **C. THE DISTRIBUTOR DEFENDANTS’ UNLAWFUL DISTRIBUTION**
23 **OF OPIOIDS.**

24 187. The Distributor Defendants owe a duty under both federal law (21
25 U.S.C. § 823, 21 CFR 1301.74) and California law (*see, e.g.*, Cal. Bus. & Prof.
26 Code § 4169.1) to monitor, detect, investigate, refuse to fill, and report suspicious
27 orders of prescription opioids originating from Plaintiffs’ Community as well as
28

1 those orders which the Distributor Defendants knew or should have known were
2 likely to be diverted into Plaintiffs' Community.

3 188. The foreseeable harm from a breach of these duties is the diversion of
4 prescription opioids for nonmedical purposes.

5 189. Each Distributor Defendant repeatedly and purposefully breached its
6 duties under state and federal law. Such breaches are a direct and proximate cause
7 of the widespread diversion of prescription opioids for nonmedical purposes into
8 Plaintiffs' Community.

9 190. The unlawful diversion of prescription opioids is a direct and
10 proximate cause and/or substantial contributing factor to the opioid epidemic,
11 prescription opioid abuse, addiction, morbidity and mortality in the State and in
12 Plaintiffs' Community. This diversion and the epidemic are direct causes of harms
13 for which Plaintiffs seek to recover here.

14 191. The opioid epidemic in the State, including *inter alia* in Plaintiffs'
15 Community, remains an immediate ***hazard to public health and safety***.

16 192. The opioid epidemic in Plaintiffs' Community is a temporary and
17 continuous ***public nuisance*** and remains unabated.

18 193. The Distributor Defendants intentionally continued their conduct, as
19 alleged herein, with knowledge that such conduct was creating the opioid nuisance
20 and causing the harms and damages alleged herein.

21 **1. Wholesale Drug Distributors Have a Duty under State and**
22 **Federal Law to Guard Against, and Report, Unlawful Diversion**
23 **and to Report and Prevent Suspicious Orders.**

24 194. As under federal law, opioids are a Schedule II controlled substance
25 under California law. *See* Cal. Health & Safety Code § 11055. Opioids are
26 categorized as "Schedule II" drugs because they have a "high potential for abuse"
27 and the potential to cause "severe psychic or physical dependence" and/or "severe
28 psychological . . . dependence." 21 U.S.C. § 812(b)(2)(A)-(C).

1 195. California law required Distributor Defendants to be licensed by the
2 California State Board of Pharmacy. Cal. Bus. & Prof. Code § 4160; Cal. Bus. &
3 Prof. Code § 4161. California law required Manufacturer Defendants to be
4 licensed by the State Department of Health Services. Cal. Health & Safety Code §
5 111615.

6 196. The California State Board of Pharmacy has the authority to “deny,
7 revoke, or suspend any license” issued to out-of-state manufacturers or wholesale
8 distributors who violate the Pharmacy Law or the state’s Sherman Food, Drug and
9 Cosmetic Law. Cal. Bus. & Prof. Code § 4304.

10 197. It is unlawful under California law for a distributor or manufacturer
11 to “furnish controlled substances for other than legitimate medical purposes.” Cal.
12 Health & Safety Code § 11153.5.

13 198. The California State Board of Pharmacy has the authority to “take
14 action against any holder of a license who is guilty of unprofessional conduct”
15 which includes “clearly excessive furnishing of controlled substances” for other
16 than legitimate medical purposes. Cal. Bus. & Prof. Code § 4301(e) (citing Cal.
17 Health & Safety Code § 11153.5). “Factors to be considered in determining
18 whether the furnishing of controlled substances is clearly excessive shall include,
19 but not be limited to, the amount of controlled substances furnished, the previous
20 ordering pattern of the customer (including size and frequency of orders), the type
21 and size of the customer, and where and to whom the customer distributes its
22 product.” *Id.*

23 199. Other examples of unprofessional conduct include procuring a
24 license by fraud or misrepresentation, gross negligence, fraud, making or signing
25 documents with false statements, and violating any state or federal statute or rule
26 regulating controlled substances. Cal. Bus. & Prof. Code § 4301.

27 200. California requires manufacturers and distributors of controlled
28 substances to maintain records of the manufacture and sale of dangerous drugs.

1 *See Cal. Bus. & Prof. Code §§ 4081; 4161(c)(2)(A); 4332; Cal. Code Regs. tit. 16,*
 2 *§§ 1780(f); 1783(e).*

3 201. Furthermore, California law incorporates federal requirements set out
 4 under the Controlled Substance Act and related controlled substance laws and
 5 regulations. *See Cal. Bus. & Prof. Code §§ 4160(d)* (representative-in-charge of
 6 wholesaler is responsible for wholesaler's compliance with applicable state and
 7 federal laws); 4301(j) (unprofessional conduct includes violating federal laws
 8 related to controlled substances); 4301(o) (unprofessional conduct includes
 9 violating, attempting to violate, assisting in or abetting or conspiring to violate any
 10 applicable federal law); Cal. Code Regs. tit. 16, § 1780(f)(2) (records required for
 11 identifying, recording and reporting losses or thefts shall be in accordance with
 12 federal regulations).

13 202. Each Distributor Defendant was further required to register with the
 14 DEA, pursuant to the federal Controlled Substance Act. *See 21 U.S.C. § 823(b),*
 15 *(e); 28 C.F.R. § 0.100.* Each Distributor Defendant is a “registrant” as a
 16 wholesale distributor in the chain of distribution of Schedule II controlled
 17 substances with a duty to comply with all security requirements imposed under
 18 that statutory scheme. California law adopts and incorporates those requirements,
 19 as set out above. *See, e.g., Cal. Code Regs. tit. 16, 1780(f)(2).*

20 203. Each Distributor Defendant has an affirmative duty under federal and
 21 California law to act as a gatekeeper guarding against the diversion of the highly
 22 addictive, dangerous opioid drugs. Federal law requires that Distributors of
 23 Schedule II drugs, including opioids, must maintain “effective control against
 24 diversion of particular controlled substances into other than legitimate medical,
 25 scientific, and industrial channels.” 21 U.S.C. §§ 823(b)(1). California law
 26 requires that “[t]he following minimum standards shall apply to all wholesale
 27 establishments for which permits have been issued by the Board: . . . (c)(2) All
 28 facilities shall be equipped with a security system that will provide suitable

1 protection against theft and diversion.” Cal. Code Regs. Tit. 16 § 1780(c)(2). In
2 addition, drug distributors shall “establish, maintain, and adhere to written policies
3 and procedures, which shall be followed for the receipt, security, storage,
4 inventory, and distribution of prescription drugs, including policies and
5 procedures for identifying, recording, and reporting losses or thefts[.]” Cal. Code
6 Regs. Tit. 16 § 1780(f)(1).

7 204. The California Legislature has found that “Protection of the public
8 shall be the highest priority for the California State Board of Pharmacy in
9 exercising its licensing, regulatory, and disciplinary functions. Whenever the
10 protection of the public is inconsistent with other interests sought to be promoted,
11 the protection of the public shall be paramount.” Cal. Bus. & Prof. Code § 4001.1.

12 205. Federal regulations and California law impose a non-delegable duty
13 upon wholesale drug distributors to “design and operate a system to disclose to the
14 registrant suspicious orders of controlled substances. The registrant [distributor]
15 shall inform the Field Division Office of the Administration in his area of
16 suspicious orders when discovered by the registrant. Suspicious orders include
17 orders of unusual size, orders deviating substantially from a normal pattern, and
18 orders of unusual frequency.” 21 C.F.R. § 1301.74(b). *See also* Cal. Bus. & Prof.
19 Code § 4169.1 (“A wholesaler, upon discovery, shall notify the board in writing of
20 any suspicious orders of controlled substances placed by a California-licensed
21 pharmacy or wholesaler by providing the board a copy of the information that the
22 wholesaler provides to the United States Drug Enforcement Administration.”);
23 Cal. Health & Safety Code § 11153.5(c) (factors considered in determining if
24 distributor or manufacturer furnished controlled substances with a conscious
25 disregard that they were being used for other than legitimate medical purposes
26 include the amount of controlled substances furnished, the size and frequency of
27 previous orders, the type and size of customer and where the customer distributes
28 the product).

1 206. “Suspicious orders” include orders of an unusual size, orders of
2 unusual frequency or orders deviating substantially from a normal pattern. *See* 21
3 CFR 1301.74(b); *see also* Cal. Bus. & Prof. Code § 4169.1. These criteria are
4 disjunctive and are not all inclusive. For example, if an order deviates
5 substantially from a normal pattern, the size of the order does not matter and the
6 order should be reported as suspicious. Likewise, a wholesale distributor need not
7 wait for a normal pattern to develop over time before determining whether a
8 particular order is suspicious. The size of an order alone, regardless of whether it
9 deviates from a normal pattern, is enough to trigger the wholesale distributor’s
10 responsibility to report the order as suspicious. The determination of whether an
11 order is suspicious depends not only on the ordering patterns of the particular
12 customer but also on the patterns of the entirety of the wholesale distributor’s
13 customer base and the patterns throughout the relevant segment of the wholesale
14 distributor industry.

15 207. In addition to reporting all suspicious orders, distributors must also
16 stop shipment on any order which is flagged as suspicious and only ship orders
17 which were flagged as potentially suspicious if, after conducting due diligence,
18 the distributor can determine that the order is not likely to be diverted into illegal
19 channels. *See Southwood Pharm., Inc.*, 72 Fed. Reg. 36,487, 36,501 (Drug Enf’t
20 Admin. July 3, 2007); *Masters Pharmaceutical, Inc. v. Drug Enforcement*
21 *Administration*, No. 15-11355 (D.C. Cir. June 30, 2017). Regardless, all flagged
22 orders must be reported. *Id.*

23 208. These prescription drugs are regulated for the purpose of providing a
24 “closed” system **intended to reduce the widespread diversion of these drugs**
25 **out of legitimate channels into the illicit market**, while at the same time

26

27

28

1 providing the legitimate drug industry with a unified approach to narcotic and
 2 dangerous drug control.¹³¹

3 209. Different entities supervise the discrete links in the chain that
 4 separate a consumer from a controlled substance. Statutes and regulations define
 5 each participant's role and responsibilities.¹³²

6 210. As the DEA advised the Distributor Defendants in a letter to them
 7 dated September 27, 2006, wholesale distributors are "one of the key components
 8 of the distribution chain. If the closed system is to function properly ...
 9 distributors must be vigilant in deciding whether a prospective customer can be
 10 trusted to deliver controlled substances only for lawful purposes. This
 11 responsibility is critical, as ... the illegal distribution of controlled substances has
 12 a substantial and detrimental effect on the health and general welfare of the
 13 American people."¹³³

14

15 ¹³¹ See 1970 U.S.C.C.A.N. 4566, 4571-72.

16 ¹³² Brief for Healthcare Distribution Management Association and National
 17 Association of Chain Drug Stores as Amici Curiae in Support of Neither Party,
Masters Pharm., Inc. v. U.S. Drug Enf't Admin. (No. 15-1335) (D.C. Cir. Apr. 4,
 18 2016), 2016 WL 1321983, at *22 [hereinafter Brief for HDMA and NACDS]. The
 19 Healthcare Distribution Management Association (HDMA or HMA)—now known
 20 as the Healthcare Distribution Alliance (HDA)—is a national, not-for-profit trade
 21 association that represents the nation's primary, full-service healthcare distributors
 22 whose membership includes, among others: AmerisourceBergen Drug
 23 Corporation, Cardinal Health, Inc., and McKesson Corporation. *See generally*
HDA, About, <https://www.healthcaredistribution.org/about> (last visited Aug. 21,
 24 2017). The National Association of Chain Drug Stores (NACDS) is a national,
 25 not-for-profit trade association that represents traditional drug stores and
 26 supermarkets and mass merchants with pharmacies whose membership includes,
 27 among others: Walgreen Company, CVS Health, Rite Aid Corporation and
 28 Walmart. *See generally NACDS, Mission*, <https://www.nacds.org/ about/mission/> (last visited Aug. 21, 2017).

125 ¹³³ See Letter from Joseph T. Rannazzisi, Deputy Assistant Adm'r, Office of
 126 Diversion Control, Drug. Enf't Admin., U.S. Dep't of Justice, to Cardinal Health
 127 (Sept. 27, 2006) [hereinafter Rannazzisi Letter] ("This letter is being sent to every
 128 commercial entity in the United States registered with the Drug Enforcement
 Agency (DEA) to distribute controlled substances. The purpose of this letter is to
 reiterate the responsibilities of controlled substance distributors in view of the
 prescription drug abuse problem our nation currently faces."), filed in *Cardinal
 Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW (D.D.C. Feb. 10, 2012), ECF No.
 14-51.

1 211. The Distributor Defendants have admitted that they are responsible
2 for reporting suspicious orders.¹³⁴

3 212. The DEA sent a letter to each of the Distributor Defendants on
4 September 27, 2006, warning that it would use its authority to revoke and suspend
5 registrations when appropriate. The letter expressly states that a distributor, *in*
6 **addition** to reporting suspicious orders, has a “statutory responsibility to exercise
7 due diligence to avoid filling suspicious orders that might be diverted into other
8 than legitimate medical, scientific, and industrial channels.”¹³⁵ The letter also
9 instructs that “distributors must be vigilant in deciding whether a prospective
10 customer can be trusted to deliver controlled substances only for lawful
11 purposes.”¹³⁶ The DEA warns that “even just one distributor that uses its DEA
12 registration to facilitate diversion can cause enormous harm.”¹³⁷

13 213. The DEA sent a second letter to each of the Distributor Defendants
14 on December 27, 2007.¹³⁸ This letter reminds the Defendants of their statutory and
15 regulatory duties to “maintain effective controls against diversion” and “design
16 and operate a system to disclose to the registrant suspicious orders of controlled
17 substances.”¹³⁹ The letter further explains:

18 The regulation also requires that the registrant inform the local DEA
19 Division Office of suspicious orders when discovered by the
registrant. Filing a monthly report of completed transactions (e.g.,
20

21 ¹³⁴ See Brief for HDMA and NACDS, 2016 WL 1321983, at *4
22 (“[R]egulations . . . in place for more than 40 years require distributors to report
23 suspicious orders of controlled substances to DEA based on information readily
available to them (e.g., a pharmacy’s placement of unusually frequent or large
orders.”).

24 ¹³⁵ Rannazzisi Letter, at 2.

25 ¹³⁶ *Id.* at 1.

26 ¹³⁷ *Id.* at 2.

27 ¹³⁸ See Letter from Joseph T. Rannazzisi, Deputy Assistant Adm’r, Office of
Diversion Control, Drug. Enf’t Admin., U.S. Dep’t of Justice, to Cardinal Health
(Dec. 27, 2007), filed in *Cardinal Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW
(D.D.C. Feb. 10, 2012), ECF No. 14-8.

28 ¹³⁹ *Id.*

1 “excessive purchase report” or “high unity purchases”) does not meet
2 the regulatory requirement to report suspicious orders. Registrants are
3 reminded that their responsibility does not end merely with the filing
4 of a suspicious order report. Registrants must conduct an independent
5 analysis of suspicious orders prior to completing a sale to determine
6 whether the controlled substances are likely to be diverted from
7 legitimate channels. Reporting an order as suspicious will not absolve
8 the registrant of responsibility if the registrant knew, or should have
9 known, that the controlled substances were being diverted.

10 The regulation specifically states that suspicious orders include orders
11 of unusual size, orders deviating substantially from a normal pattern,
12 and orders of an unusual frequency. These criteria are disjunctive and
13 are not all inclusive. For example, if an order deviates substantially
14 from a normal pattern, the size of the order does not matter and the
15 order should be reported as suspicious. Likewise, a registrant need
16 not wait for a “normal pattern” to develop over time before
17 determining whether a particular order is suspicious. The size of an
18 order alone, whether or not it deviates from a normal pattern, is
19 enough to trigger the registrant’s responsibility to report the order as
20 suspicious. The determination of whether an order is suspicious
21 depends not only on the ordering patterns of the particular customer,
22 but also on the patterns of the registrant’s customer base and the
23 patterns throughout the segment of the regulated industry.

24 Registrants that rely on rigid formulas to define whether an order is
25 suspicious may be failing to detect suspicious orders. For example, a
26 system that identifies orders as suspicious only if the total amount of a
27 controlled substance ordered during one month exceeds the amount
28 ordered the previous month by a certain percentage or more is
insufficient. This system fails to identify orders placed by a pharmacy
if the pharmacy placed unusually large orders from the beginning of
its relationship with the distributor. Also, this system would not
identify orders as suspicious if the order were solely for one highly
abused controlled substance if the orders never grew substantially.
Nevertheless, ordering one highly abused controlled substance and
little or nothing else deviates from the normal pattern of what
pharmacies generally order.

29 When reporting an order as suspicious, registrants must be clear in
30 their communication with DEA that the registrant is actually
31 characterizing an order as suspicious. Daily, weekly, or monthly
32 reports submitted by registrant indicating “excessive purchases” do
33 not comply with the requirement to report suspicious orders, even if
the registrant calls such reports “suspicious order reports.”

34 Lastly, registrants that routinely report suspicious orders, yet fill these
35 orders without first determining that order is not being diverted into
36 other than legitimate medical, scientific, and industrial channels, may
37 be failing to maintain effective controls against diversion. Failure to
38 maintain effective controls against diversion is inconsistent with the
39 public interest as that term is used in 21 USC 823 and 824, and may

1 result in the revocation of the registrant's DEA Certificate of
 2 Registration.¹⁴⁰

3 Finally, the DEA letter references the Revocation of Registration issued in
 4 *Southwood Pharmaceuticals, Inc.*, 72 Fed. Reg. 36,487-01 (July 3, 2007), which
 5 discusses the obligation to report suspicious orders and "some criteria to use when
 determining whether an order is suspicious."¹⁴¹

6 214. The Distributor Defendants admit that they "have not only statutory
 7 and regulatory responsibilities to detect and prevent diversion of controlled
 8 prescription drugs, but undertake such efforts as responsible members of
 9 society."¹⁴²

10 215. The Distributor Defendants knew they were required to monitor,
 11 detect, and halt suspicious orders. Industry compliance guidelines established by
 12 the Healthcare Distribution Management Association, the trade association of
 13 pharmaceutical distributors, explain that distributors are "[a]t the center of a
 14 sophisticated supply chain" and therefore "are uniquely situated to perform due
 15 diligence in order to help support the security of the controlled substances they
 16 deliver to their customers." The guidelines set forth recommended steps in the
 17 "due diligence" process, and note in particular: If an order meets or exceeds a
 18 distributor's threshold, as defined in the distributor's monitoring system, or is
 19 otherwise characterized by the distributor as an order of interest, the distributor
 20 should not ship to the customer, in fulfillment of that order, any units of the
 21 specific drug code product as to which the order met or exceeded a threshold or as
 22 to which the order was otherwise characterized as an order of interest.¹⁴³

23
 24
 25

¹⁴⁰ *Id.*

26
¹⁴¹ *Id.*

27
¹⁴² See Brief of HDMA, 2012 WL 1637016, at *2.

28
¹⁴³ Healthcare Distribution Management Association (HDMA) Industry
 Compliance Guidelines: Reporting Suspicious Orders and Preventing Diversion of
 Controlled Substances, filed in *Cardinal Health, Inc. v. Holder*, No. 12-5061 (D.C.
 Cir. Mar. 7, 2012), Doc. No. 1362415 (App'x B).

1 216. Each of the Distributor Defendants sold prescription opioids,
2 including hydrocodone and/or oxycodone, to retailers in Plaintiffs' Community
3 and/or to retailers from which Defendants knew prescription opioids were likely
4 to be diverted to Plaintiffs' Community.

5 217. Each Distributor Defendant owes a duty to monitor and detect
6 suspicious orders of prescription opioids.

7 218. Each Distributor Defendant owes a duty under federal and state law
8 to investigate and refuse suspicious orders of prescription opioids.

9 219. Each Distributor Defendant owes a duty under federal and state law
10 to report suspicious orders of prescription opioids.

11 220. Each Distributor Defendant owes a duty under federal and state law
12 to prevent the diversion of prescription opioids into illicit markets in the State and
13 Plaintiffs' Community.

14 221. The foreseeable harm resulting from a breach of these duties is the
15 diversion of prescription opioids for nonmedical purposes and subsequent plague
16 of opioid addiction.

17 222. The foreseeable harm resulting from the diversion of prescription
18 opioids for nonmedical purposes is abuse, addiction, morbidity and mortality in
19 Plaintiffs' Community and the damages caused thereby.

20 **2. The Distributor Defendants Breached Their Duties.**

21 223. Because distributors handle such large volumes of controlled
22 substances, and are the first major line of defense in the movement of legal
23 pharmaceutical controlled substances from legitimate channels into the illicit
24 market, it is incumbent on distributors to maintain effective controls to prevent
25 diversion of controlled substances. Should a distributor deviate from these checks
26 and balances, the closed system collapses.¹⁴⁴

27
28

¹⁴⁴ See Rannazzisi Decl. ¶ 10, filed in *Cardinal Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW (D.D.C. Feb. 10, 2012), ECF No. 14-2.

1 224. The sheer volume of prescription opioids distributed to pharmacies in
2 the Plaintiffs' Community, and/or to pharmacies from which the Distributor
3 Defendants knew the opioids were likely to be diverted into Plaintiffs'
4 Community, is excessive for the medical need of the community and facially
5 suspicious. Some red flags are so obvious that no one who engages in the
6 legitimate distribution of controlled substances can reasonably claim ignorance of
7 them.¹⁴⁵

8 225. The Distributor Defendants failed to report “suspicious orders”
9 originating from Plaintiffs’ Community, or which the Distributor Defendants
10 knew were likely to be diverted to Plaintiffs’ Community, to the federal and state
11 authorities, including the DEA and/or the state Board of Pharmacy.

12 226. The Distributor Defendants unlawfully filled suspicious orders of
13 unusual size, orders deviating substantially from a normal pattern and/or orders of
14 unusual frequency in Plaintiffs' Community, and/or in areas from which the
15 Distributor Defendants knew opioids were likely to be diverted to Plaintiffs'
16 Community.

17 227. The Distributor Defendants breached their duty to monitor, detect,
18 investigate, refuse and report suspicious orders of prescription opiates originating
19 from Plaintiffs' Community, and/or in areas from which the Distributor
20 Defendants knew opioids were likely to be diverted to Plaintiffs' Community.

21 228. The Distributor Defendants breached their duty to maintain effective
22 controls against diversion of prescription opiates into other than legitimate
23 medical, scientific, and industrial channels.

24 229. The Distributor Defendants breached their duty to “design and
25 operate a system to disclose to the registrant suspicious orders of controlled

¹⁴⁵ Masters Pharmaceuticals, Inc., 80 Fed. Reg. 55,418-01, 55,482 (Sept. 15, 2015) (citing Holiday CVS, L.L.C., d/b/a CVS/Pharmacy Nos. 219 and 5195, 77 Fed. Reg. 62,316, 62,322 (2012)).

1 substances” and failed to inform the authorities including the DEA of suspicious
2 orders when discovered, in violation of their duties under federal and state law.

3 230. The Distributor Defendants breached their duty to exercise due
4 diligence to avoid filling suspicious orders that might be diverted into channels
5 other than legitimate medical, scientific and industrial channels.¹⁴⁶

6 231. The federal and state laws at issue here are public safety laws.

7 232. The Distributor Defendants’ violations of public safety statutes
8 constitute *prima facie* evidence of negligence under State law.

9 233. The Distributor Defendants supplied prescription opioids to
10 obviously suspicious physicians and pharmacies, enabled the illegal diversion of
11 opioids, aided criminal activity, and disseminated massive quantities of
12 prescription opioids into the black market.

13 234. The unlawful conduct by the Distributor Defendants is purposeful
14 and intentional. The Distributor Defendants refuse to abide by the duties imposed
15 by federal and state law which are required to legally acquire and maintain a
16 license to distribute prescription opiates.

17 235. The Distributor Defendants acted with actual malice in breaching
18 their duties, *i.e.*, they have acted with a conscious disregard for the rights and
19 safety of other persons, and said actions have a great probability of causing
20 substantial harm.

21 236. The Distributor Defendants’ repeated shipments of suspicious orders,
22 over an extended period of time, in violation of public safety statutes, and without
23 reporting the suspicious orders to the relevant authorities demonstrates wanton,
24 willful, or reckless conduct or criminal indifference to civil obligations affecting
25 the rights of others.

26

27

28

¹⁴⁶ See *Cardinal Health, Inc. v. Holder*, 846 F. Supp. 2d 203, 206 (D.D.C. 2012).

1 **3. The Distributor Defendants Have Sought to Avoid and Have**
 2 **Misrepresented their Compliance with Their Legal Duties.**

3 237. The Distributor Defendants have repeatedly misrepresented their
 4 compliance with their legal duties under state and federal law and have wrongfully
 5 and repeatedly disavowed those duties in an effort to mislead regulators and the
 6 public regarding the Distributor Defendants' compliance with their legal duties.

7 238. Distributor Defendants have refused to recognize any duty beyond
 8 *reporting* suspicious orders. In *Masters Pharmaceuticals*, the HDMA, a trade
 9 association run by the Distributor Defendants, and the NACDS submitted amicus
 10 briefs regarding the legal duty of wholesale distributors. Inaccurately denying the
 11 legal duties that the wholesale drug industry has been tragically recalcitrant in
 12 performing, they argued as follows:

- 13 a. The Associations complained that the “DEA has required distributors
 not only to report suspicious orders, but to *investigate* orders (e.g., by
 interrogating pharmacies and physicians) and take action to *halt*
 suspicious orders before they are filled.”¹⁴⁷
- 14 b. The Associations argued that, “DEA now appears to have changed its
 position to require that distributors not only *report* suspicious orders,
 but *investigate* and *halt* suspicious orders. Such a change in agency
 position must be accompanied by an acknowledgment of the change
 and a reasoned explanation for it. In other words, an agency must
 display awareness that it *is* changing position and show that there are
 good reasons for the new policy. This is especially important here,
 because imposing intrusive obligations on distributors threatens to
 disrupt patient access to needed prescription medications.”¹⁴⁸
- 15 c. The Associations alleged (inaccurately) that nothing “requires
 distributors to investigate the legitimacy of orders, or to halt
 shipment of any orders deemed to be suspicious.”¹⁴⁹
- 16 d. The Association complained that the purported “practical infeasibility
 of requiring distributors to investigate and halt suspicious orders (as
 well as report them) underscores the importance of ensuring that
 DEA has complied with the APA before attempting to impose such
 duties.”¹⁵⁰

26

¹⁴⁷ Brief for HDMA and NACDS, 2016 WL 1321983, at *4–5.

27 ¹⁴⁸ *Id.* at *8 (citations and quotation marks omitted).

28 ¹⁴⁹ *Id.* at *14.

¹⁵⁰ *Id.* at *22.

1 e. The Associations alleged (inaccurately) that “DEA’s regulations []
 2 sensibly impose[] a duty on distributors simply to *report* suspicious
 3 orders, but left it to DEA and its agents to investigate and halt
 4 suspicious orders.”¹⁵¹

5 f. Also inaccurately, the Associations argued that, “[i]mposing a duty
 6 on distributors – which lack the patient information and the necessary
 7 medical expertise – to investigate and halt orders may force
 8 distributors to take a shot-in-the-dark approach to complying with
 9 DEA’s demands.”¹⁵²

10 239. The positions taken by the trade groups is emblematic of the position
 11 taken by the Distributor Defendants in a futile attempt to deny their legal
 12 obligations to prevent diversion of the dangerous drugs.¹⁵³

13 240. The Court of Appeals for the District of Columbia recently issued its
 14 opinion affirming that a wholesale drug distributor does, in fact, have duties
 15 beyond reporting. *Masters Pharm., Inc. v. Drug Enf’t Admin.*, 861 F.3d 206 (D.C.
 16 Cir. 2017). The D.C. Circuit Court upheld the revocation of Master
 17 Pharmaceutical’s license and determined that DEA regulations require that in
 18 addition to reporting suspicious orders, distributors must “decline to ship the
 19 order, or conduct some ‘due diligence’ and—if it is able to determine that the
 20 order is not likely to be diverted into illegal channels—ship the order.” *Id.* at 212.
 21 Master Pharmaceutical was in violation of legal requirements because it failed to
 22 conduct necessary investigations and filled suspicious orders. *Id.* at 218–19, 226.
 23 A distributor’s investigation must dispel all the red flags giving rise to suspicious
 24 circumstances prior to shipping a suspicious order. *Id.* at 226. The Circuit Court
 25 also rejected the argument made by the HDMA and NACDS (quoted above), that,
 26 allegedly, the DEA had created or imposed new duties. *Id.* at 220.

27 241. Wholesale Distributor McKesson has recently been forced to
 28 specifically admit to breach of its duties to monitor, report, and prevent suspicious

26 ¹⁵¹ *Id.* at *24–25.

27 ¹⁵² *Id.* at *26.

28 ¹⁵³ See Brief of HDMA, 2012 WL 1637016, at *3 (arguing the wholesale
 distributor industry “does not know the rules of the road because” they claim
 (inaccurately) that the “DEA has not adequately explained them”).

1 orders. Pursuant to an Administrative Memorandum of Agreement (“2017
 2 Agreement”) entered into between McKesson and the DEA in January 2017,
 3 McKesson admitted that, at various times during the period from January 1, 2009
 4 through the effective date of the Agreement (January 17, 2017) it “did not identify
 5 or report to [the] DEA certain orders placed by certain pharmacies which should
 6 have been detected by McKesson as suspicious based on the guidance contained
 7 in the DEA Letters.”¹⁵⁴ Further, the 2017 Agreement specifically finds that
 8 McKesson “distributed controlled substances to pharmacies even though those
 9 McKesson Distribution Centers should have known that the pharmacists
 10 practicing within those pharmacies had failed to fulfill their corresponding
 11 responsibility to ensure that controlled substances were dispensed pursuant to
 12 prescriptions issued for legitimate medical purposes by practitioners acting in the
 13 usual course of their professional practice, as required by 21 C.F.R
 14 § 1306.04(a).”¹⁵⁵ McKesson admitted that, during this time period, it “failed to
 15 maintain effective controls against diversion of particular controlled substances
 16 into other than legitimate medical, scientific and industrial channels by sales to
 17 certain of its customers in violation of the CSA and the CSA’s implementing
 18 regulations, 21 C.F.R. Part 1300 *et seq.*, at the McKesson Distribution Centers.”¹⁵⁶
 19 Due to these violations, McKesson agreed that its authority to distribute controlled
 20 substances from numerous facilities would be partially suspended.¹⁵⁷

21 242. The 2017 Memorandum of Agreement followed a 2008 Settlement
 22 Agreement in which McKesson also admitted failure to report suspicious orders of
 23
 24

25 ¹⁵⁴ See Administrative Memorandum of Agreement between the U.S. Dep’t of
 26 Justice, the Drug Enf’t Admin., and the McKesson Corp. (Jan. 17, 2017),
<https://www.justice.gov/opa/press-release/file/928476/download>.

27 ¹⁵⁵ *Id.* at 4.

28 ¹⁵⁶ *Id.*

29 ¹⁵⁷ *Id.* at 6.

1 controlled substances to the DEA.¹⁵⁸ In the 2008 Settlement Agreement,
 2 McKesson “recognized that it had a duty to monitor its sales of all controlled
 3 substances and report suspicious orders to DEA,” but had failed to do so.¹⁵⁹ The
 4 2017 Memorandum of Agreement documents that McKesson continued to breach
 5 its admitted duties by “fail[ing] to properly monitor its sales of controlled
 6 substances and/or report suspicious orders to DEA, in accordance with
 7 McKesson’s obligations.”¹⁶⁰ As a result of these violations, McKesson was fined
 8 and required to pay to the United States \$150,000,000.¹⁶¹

9 243. Even though McKesson had been sanctioned in 2008 for failure to
 10 comply with its legal obligations regarding controlling diversion and reporting
 11 suspicious orders, and even though McKesson had specifically agreed in 2008 that
 12 it would no longer violate those obligations, McKesson continued to violate the
 13 laws in contrast to its written agreement not to do so.

14 244. Because of the Distributor Defendants’ refusal to abide by their legal
 15 obligations, the DEA has repeatedly taken administrative action to attempt to
 16 force compliance. For example, in May 2014, the United States Department of
 17 Justice, Office of the Inspector General, Evaluation and Inspections Divisions,
 18 reported that the DEA issued final decisions in 178 registrant actions between
 19 2008 and 2012.¹⁶² The Office of Administrative Law Judges issued a
 20

21 ¹⁵⁸ *Id.* at 4.

22 ¹⁵⁹ *Id.*

23 ¹⁶⁰ *Id.*; see also Settlement Agreement and Release between the U.S. and
 24 McKesson Corp., at 5 (Jan. 17, 2017) [hereinafter 2017 Settlement Agreement and
 25 Release] (“McKesson acknowledges that, at various times during the Covered
 26 Time Period [2009-2017], it did not identify or report to DEA certain orders placed
 27 by certain pharmacies, which should have been detected by McKesson as
 28 suspicious, in a manner fully consistent with the requirements set forth in the 2008
 MOA.”), <https://www.justice.gov/opa/press-release/file/928471/download>.

1 ¹⁶¹ See 2017 Settlement Agreement and Release, at 6.

2 ¹⁶² Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep’t of
 3 Justice, *The Drug Enforcement Administration’s Adjudication of Registrant*
 4 *Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 recommended decision in a total of 117 registrant actions before the DEA issued
 2 its final decision, including 76 actions involving orders to show cause and 41
 3 actions involving immediate suspension orders.¹⁶³ These actions include the
 4 following:

- 5 a. On April 24, 2007, the DEA issued an *Order to Show Cause and*
 Immediate Suspension Order against the AmerisourceBergen
 Orlando, Florida distribution center (“Orlando Facility”) alleging
 failure to maintain effective controls against diversion of controlled
 substances. On June 22, 2007, AmerisourceBergen entered into a
 settlement that resulted in the suspension of its DEA registration;
- 6 b. On November 28, 2007, the DEA issued an *Order to Show Cause*
 and Immediate Suspension Order against the Cardinal Health
 Auburn, Washington Distribution Center (“Auburn Facility”) for
 failure to maintain effective controls against diversion of
 hydrocodone;
- 7 c. On December 5, 2007, the DEA issued an *Order to Show Cause and*
 Immediate Suspension Order against the Cardinal Health Lakeland,
 Florida Distribution Center (“Lakeland Facility”) for failure to
 maintain effective controls against diversion of hydrocodone;
- 8 d. On December 7, 2007, the DEA issued an *Order to Show Cause and*
 Immediate Suspension Order against the Cardinal Health Swedesboro,
 New Jersey Distribution Center (“Swedesboro Facility”) for failure to maintain
 effective controls against diversion of hydrocodone;
- 9 e. On January 30, 2008, the DEA issued an *Order to Show Cause and*
 Immediate Suspension Order against the Cardinal Health Stafford,
 Texas Distribution Center (“Stafford Facility”) for failure to maintain
 effective controls against diversion of hydrocodone;
- 10 f. On May 2, 2008, McKesson Corporation entered into an
 Administrative Memorandum of Agreement (“2008 MOA”) with the
 DEA which provided that McKesson would “maintain a compliance
 program designed to detect and prevent the diversion of controlled
 substances, inform DEA of suspicious orders required by 21 C.F.R. §
 1301.74(b), and follow the procedures established by its Controlled
 Substance Monitoring Program”;
- 11 g. On September 30, 2008, Cardinal Health entered into a *Settlement*
 and Release Agreement and Administrative Memorandum of
 Agreement with the DEA related to its Auburn Facility, Lakeland
 Facility, Swedesboro Facility and Stafford Facility. The document
 also referenced allegations by the DEA that Cardinal failed to
 maintain effective controls against the diversion of controlled
 substances at its distribution facilities located in McDonough,

28 ¹⁶³ *Id.*

Georgia (“McDonough Facility”), Valencia, California (“Valencia Facility”) and Denver, Colorado (“Denver Facility”);

- h. On February 2, 2012, the DEA issued an *Order to Show Cause and Immediate Suspension Order* against the Cardinal Health Lakeland, Florida Distribution Center ("Lakeland Facility") for failure to maintain effective controls against diversion of oxycodone;
 - i. On December 23, 2016, Cardinal Health agreed to pay a \$44 million fine to the DEA to resolve the civil penalty portion of the administrative action taken against its Lakeland, Florida Distribution Center; and
 - j. On January 5, 2017, McKesson Corporation entered into an *Administrative Memorandum Agreement* with the DEA wherein it agreed to pay a \$150 million civil penalty for violation of the 2008 MOA as well as failure to identify and report suspicious orders at its facilities in Aurora CO, Aurora IL, Delran NJ, LaCrosse WI, Lakeland FL, Landover MD, La Vista NE, Livonia MI, Methuen MA, Santa Fe Springs CA, Washington Courthouse OH and West Sacramento CA.

245. Rather than abide by their non-delegable duties under public safety laws, the Distributor Defendants, individually and collectively through trade groups in the industry, pressured the U.S. Department of Justice to “halt” prosecutions and lobbied Congress to strip the DEA of its ability to immediately suspend distributor registrations. The result was a “sharp drop in enforcement actions” and the passage of the “Ensuring Patient Access and Effective Drug Enforcement Act” which, ironically, raised the burden for the DEA to revoke a distributor’s license from “imminent harm” to “immediate harm” and provided the industry the right to “cure” any violations of law before a suspension order can be issued.¹⁶⁴

¹⁶⁴ See Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html; Lenny Bernstein & Scott Higham, *Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017, https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html; Eric Eyre, *DEA Agent: “We Had No Leadership” in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017, <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1 246. In addition to taking actions to limit regulatory prosecutions and
 2 suspensions, the Distributor Defendants undertook to fraudulently convince the
 3 public that they were complying with their legal obligations, including those
 4 imposed by licensing regulations. Through such statements, the Distributor
 5 Defendants attempted to assure the public they were working to curb the opioid
 6 epidemic.

7 247. For example, a Cardinal Health executive claimed that it uses
 8 “advanced analytics” to monitor its supply chain, and represented that it was being
 9 “as effective and efficient as possible in constantly monitoring, identifying, and
 10 eliminating any outside criminal activity.”¹⁶⁵ Given the sales volumes and the
 11 company’s history of violations, this executive was either not telling the truth, or,
 12 if Cardinal Health had such a system, it ignored the results.

13 248. Similarly, Defendant McKesson publicly stated that it has a “best-in-
 14 class controlled substance monitoring program to help identify suspicious orders,”
 15 and claimed it is “deeply passionate about curbing the opioid epidemic in our
 16 country.”¹⁶⁶ Again, given McKesson’s historical conduct, this statement is either
 17 false, or the company ignored outputs of the monitoring program.

18 249. By misleading the public about the effectiveness of their controlled
 19 substance monitoring programs, the Distributor Defendants successfully
 20 concealed the facts sufficient to arouse suspicion of the claims that the Plaintiffs
 21 now assert. The Plaintiffs did not know of the existence or scope of Defendants’
 22

23
 24 ¹⁶⁵ Lenny Bernstein et al., *How Drugs Intended for Patients Ended Up in the*
25 Hands of Illegal Users: “No One Was Doing Their Job,” Wash. Post, Oct. 22,
26 2016, https://www.washingtonpost.com/investigations/how-drugs-intended-for-patients-ended-up-in-the-hands-of-illegal-users-no-one-was-doing-their-job/2016/10/22/10e79396-30a7-11e6-8ff7-7b6c1998b7a0_story.html.

27 ¹⁶⁶ Scott Higham et al., *Drug Industry Hired Dozens of Officials from the DEA as the Agency Tried to Curb Opioid Abuse,* Wash. Post, Dec. 22, 2016,
28 https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e_story.html.

1 industry-wide fraud and could not have acquired such knowledge earlier through
2 the exercise of reasonable diligence.

3 250. Meanwhile, the opioid epidemic rages unabated in the Nation, the
4 State, and in Plaintiffs' Community.

5 251. The epidemic still rages because the fines and suspensions imposed
6 by the DEA do not change the conduct of the industry. The distributors, including
7 the Distributor Defendants, pay fines as a cost of doing business in an industry
8 that generates billions of dollars in annual revenue. They hold multiple DEA
9 registration numbers and when one facility is suspended, they simply ship from
10 another facility.

11 252. The wrongful actions and omissions of the Distributor Defendants
12 which have caused the diversion of opioids and which have been a substantial
13 contributing factor to and/or proximate cause of the opioid crisis are alleged in
14 greater detail in the racketeering allegations below.

15 253. The Distributor Defendants have abandoned their duties imposed
16 under federal and state law, taken advantage of a lack of DEA law enforcement,
17 and abused the privilege of distributing controlled substances in the State and
18 Plaintiffs' Community.

4. The National Retail Pharmacies Were on Notice of and Contributed to Illegal Diversion of Prescription Opioids

21 254. National retail pharmacy chains earned enormous profits by flooding
22 the country with prescription opioids.¹⁶⁷ They were keenly aware of the
23 oversupply of prescription opioids through the extensive data and information
24 they developed and maintained as both distributors and dispensaries. Yet, instead

²⁷ ¹⁶⁷ The allegations contained in this Complaint are based, in part, on discovery that
²⁸ is in its infancy. Plaintiffs do not have access to transactional ARCos data for California. Accordingly, Plaintiffs reserve their right to further amend this complaint to add supporting allegations, claims and parties.

1 of taking any meaningful action to stem the flow of opioids into communities,
2 they continued to participate in the oversupply and profit from it.

3 255. Each of the National Retail Pharmacies does substantial business
4 throughout the United States. This business includes the distribution and
5 dispensing of prescription opioids.

6 256. On information and belief, the National Retail Pharmacies distributed
7 and dispensed substantial quantities of prescription opioids, including fentanyl,
8 hydrocodone, and oxycodone in California. In addition, they distributed and
9 dispensed substantial quantities of prescription opioids in other states, and these
10 drugs were diverted from these other states to California. The National Retail
11 Pharmacies failed to take meaningful action to stop this diversion despite their
12 knowledge of it, and contributed substantially to the diversion problem.

13 257. The National Retail Pharmacies developed and maintained extensive
14 data on opioids they distributed and dispensed. Through this data, National Retail
15 Pharmacies had direct knowledge of patterns and instances of improper
16 distribution, prescribing, and use of prescription opioids in communities
17 throughout the country, and in California in particular. They used the data to
18 evaluate their own sales activities and workforce. On information and belief, the
19 National Retail Pharmacies also provided Defendants with data regarding, *inter*
20 *alia*, individual doctors in exchange for rebates or other forms of consideration.
21 The National Retail Pharmacies' data is a valuable resource that they could have
22 used to help stop diversion, but failed to do so.

23 **a. The National Retail Pharmacies Have a Duty to Prevent Division**

24 258. Each participant in the supply chain of opioid distribution, including
25 the National Retail Pharmacies, is responsible for preventing diversion of
26 prescription opioids into the illegal market by, among other things, monitoring
27 and reporting suspicious activity.

28

1 259. The National Retail Pharmacies, like manufacturers and other
2 distributors, are registrants under the CSA. 21 C.F.R. § 1301.11. Under the CSA,
3 pharmacy registrants are required to “provide effective controls and procedures to
4 guard against theft and diversion of controlled substances.” See 21 C.F.R. §
5 1301.71(a). In addition, 21 C.F.R. § 1306.04(a) states, “[t]he responsibility for the
6 proper prescribing and dispensing of controlled substances is upon the prescribing
7 practitioner, but a corresponding responsibility rests with the pharmacist who fills
8 the prescription.” Because pharmacies themselves are registrants under the CSA,
9 the duty to prevent diversion lies with the pharmacy entity, not the individual
10 pharmacist alone.

11 260. The DEA, among others, has provided extensive guidance to
12 pharmacies concerning their duties to the public. The guidance advises
13 pharmacies how to identify suspicious orders and other evidence of diversion.

14 261. Suspicious pharmacy orders include orders of unusually large size,
15 orders that are disproportionately large in comparison to the population of a
16 community served by the pharmacy, orders that deviate from a normal pattern
17 and/or orders of unusual frequency and duration, among others.

18 262. Additional types of suspicious orders include: (1) prescriptions
19 written by a doctor who writes significantly more prescriptions (or in larger
20 quantities or higher doses) for controlled substances compared to other
21 practitioners in the area; (2) prescriptions which should last for a month in
22 legitimate use, but are being refilled on a shorter basis; (3) prescriptions for
23 antagonistic drugs, such as depressants and stimulants, at the same time; (4)
24 prescriptions that look “too good” or where the prescriber’s handwriting is too
25 legible; (5) prescriptions with quantities or doses that differ from usual medical
26 usage; (6) prescriptions that do not comply with standard abbreviations and/or
27 contain no abbreviations; (7) photocopied prescriptions; or (8) prescriptions
28

1 containing different handwriting. Most of the time, these attributes are not
2 difficult to detect and should be easily recognizable by pharmacies.

3 263. Suspicious pharmacy orders are red flags for if not direct evidence of
4 diversion.

5 264. Other signs of diversion can be observed through data gathered,
6 consolidated, and analyzed by the National Retail Pharmacies themselves. That
7 data allows them to observe patterns or instances of dispensing that are potentially
8 suspicious, of oversupply in particular stores or geographic areas, or of prescribers
9 or facilities that seem to engage in improper prescribing.

10 265. According to industry standards, if a pharmacy finds evidence of
11 prescription diversion, the local Board of Pharmacy and DEA must be contacted.

12 266. Despite their legal obligations as registrants under the CSA, the
13 National Retail Pharmacies allowed widespread diversion to occur—and they did
14 so knowingly.

15 267. Performance metrics and prescription quotas adopted by the National
16 Retail Pharmacies for their retail stores contributed to their failure. Under CVS's
17 Metrics System, for example, pharmacists are directed to meet high goals that
18 make it difficult, if not impossible, to comply with applicable laws and
19 regulations. There is no measurement for pharmacy accuracy or customer safety.
20 Moreover, the bonuses for pharmacists are calculated, in part, on how many
21 prescriptions that pharmacist fills within a year. The result is both deeply
22 troubling and entirely predictable: opioids flowed out of National Retail
23 Pharmacies and into communities throughout the country. The policies remained
24 in place even as the epidemic raged.

25 268. Upon information and belief, this problem was compounded by the
26 Pharmacies' failure to adequately train their pharmacists and pharmacy
27 technicians on how to properly and adequately handle prescriptions for opioid
28 painkillers, including what constitutes a proper inquiry into whether a prescription

1 is legitimate, whether a prescription is likely for a condition for which the FDA
2 has approved treatments with opioids, and what measures and/or actions to take
3 when a prescription is identified as phony, false, forged, or otherwise illegal, or
4 when suspicious circumstances are present, including when prescriptions are
5 procured and pills supplied for the purpose of illegal diversion and drug
6 trafficking.

7 269. Upon information and belief, the National Retail Pharmacies also
8 failed to adequately use data available to them to identify doctors who were
9 writing suspicious numbers of prescriptions and/or prescriptions of suspicious
10 amounts of opioids, or to adequately use data available to them to do statistical
11 analysis to prevent the filling of prescriptions that were illegally diverted or
12 otherwise contributed to the opioid crisis.

13 270. Upon information and belief, the National Retail Pharmacies failed to
14 analyze: (a) the number of opioid prescriptions filled by individual pharmacies
15 relative to the population of the pharmacy's community; (b) the increase in opioid
16 sales relative to past years; (c) the number of opioid prescriptions filled relative to
17 other drugs; and (d) the increase in annual opioid sales relative to the increase in
18 annual sales of other drugs.

19 271. Upon information and belief, the National Retail Pharmacies also
20 failed to conduct adequate internal or external audits of their opioid sales to
21 identify patterns regarding prescriptions that should not have been filled and to
22 create policies accordingly, or if they conducted such audits, they failed to take
23 any meaningful action as a result.

24 272. Upon information and belief, the National Retail Pharmacies also
25 failed to effectively respond to concerns raised by their own employees regarding
26 inadequate policies and procedures regarding the filling of opioid prescriptions.

27 273. The National Retail Pharmacies were, or should have been, fully
28 aware that the quantity of opioids being distributed and dispensed by them was

1 untenable, and in many areas patently absurd; yet, they did not take meaningful
2 action to investigate or to ensure that they were complying with their duties and
3 obligations under the law with regard to controlled substances.

4 **b. Multiple Enforcement Actions against the National Retail
5 Pharmacies Confirm their Compliance Failures.**

6 274. The National Retail Pharmacies have long been on notice of their
7 failure to abide by state and federal law and regulations governing the distribution
8 and dispensing of prescription opioids. Indeed, several of the National Retail
9 Pharmacies have been repeatedly penalized for their illegal prescription opioid
10 practices. Upon information and belief, based upon the widespread nature of these
11 violations, these enforcement actions are the product of, and confirm, national
12 policies and practices of the National Retail Pharmacies.

13 **i. CVS**

14 275. CVS is one of the largest companies in the world, with annual
15 revenue of more than \$150 billion. According to news reports, it manages
16 medications for nearly 90 million customers at 9,700 retail locations. CVS could
17 be a force for good in connection with the opioid crisis, but like other Defendants,
18 CVS sought profits over people.

19 276. CVS is a repeat offender and recidivist: the company has paid fines
20 totaling over \$40 million as the result of a series of investigations by the DEA and
21 the United States Department of Justice (“DOJ”). It nonetheless treated these fines
22 as the cost of doing business and has allowed its pharmacies to continue
23 dispensing opioids in quantities significantly higher than any plausible medical
24 need would require, and to continue violating its recordkeeping and dispensing
25 obligations under the CSA.

26 277. As recently as July 2017, CVS entered into a \$5 million settlement
27 with the U.S. Attorney’s Office for the Eastern District of California regarding
28

1 allegations that its pharmacies failed to keep and maintain accurate records of
2 Schedule II, III, IV, and V controlled substances.¹⁶⁸

3 278. This fine was preceded by numerous others throughout the country.

4 279. In February 2016, CVS paid \$8 million to settle allegations made by
5 the DEA and the DOJ that from 2008-2012, CVS stores and pharmacists in
6 Maryland violated their duties under the CSA and filled prescriptions with no
7 legitimate medical purpose.¹⁶⁹

8 280. In October 2016, CVS paid \$600,000 to settle allegations by the DOJ
9 that stores in Connecticut failed to maintain proper records in accordance with the
10 CSA.¹⁷⁰

11 281. In September 2016, CVS entered into a \$795,000 settlement with the
12 Massachusetts Attorney General wherein CVS agreed to require pharmacy staff to
13 access the state's prescription monitoring program website and review a patient's
14 prescription history before dispensing certain opioid drugs.¹⁷¹

15 282. In June 2016, CVS agreed to pay the DOJ \$3.5 million to resolve
16 allegations that 50 of its stores violated the CSA by filling forged prescriptions for
17

19
20 ¹⁶⁸ Press Release, U.S. Attorney's Office E. Dist. of Cal., *CVS Pharmacy Inc. Pays*
21 *\$5M to Settle Alleged Violations of the Controlled Substance Act*, U.S. Dep't of
22 Just. (July 11, 2017), <https://www.justice.gov/usao-edca/pr/cvs-pharmacy-inc-pays-5m-settle-alleged-violations-controlled-substance-act>.

23 ¹⁶⁹ Press Release, U.S. Attorney's Office Dist. of Md., *United States Reaches \$8*
24 *Million Settlement Agreement with CVS for Unlawful Distribution of Controlled*
25 *Substances*, U.S. Dep't of Just. (Feb. 12, 2016), <https://www.justice.gov/usao-md/pr/united-states-reaches-8-million-settlement-agreement-cvs-unlawful-distribution-controlled>.

26 ¹⁷⁰ Press Release, U.S. Attorney's Office Dist. of Conn., *CVS Pharmacy Pays \$600,000 to Settle Controlled Substances Act Allegations*, U.S. Dep't of Just. (Oct. 20, 2016), <https://www.justice.gov/usao-ct/pr/cvs-pharmacy-pays-600000-settle-controlled-substances-act-allegations>.

27 ¹⁷¹ Dialynn Dwyer, *CVS will pay \$795,000, strengthen policies around dispensing opioids in agreement with state*, Boston.com (Sept. 1, 2016),
28 <https://www.boston.com/news/local-news/2016/09/01/cvs-will-pay-795000-strengthen-policies-around-dispensing-opioids-in-agreement-with-state>.

1 controlled substances—mostly addictive painkillers—more than 500 times
 2 between 2011 and 2014.¹⁷²

3 283. In August 2015, CVS entered into a \$450,000 settlement with the
 4 U.S. Attorney’s Office for the District of Rhode Island to resolve allegations that
 5 several of its Rhode Island stores violated the CSA by filling invalid prescriptions
 6 and maintaining deficient records. The United States alleged that CVS retail
 7 pharmacies in Rhode Island filled a number of forged prescriptions with invalid
 8 DEA numbers, and filled multiple prescriptions written by psychiatric nurse
 9 practitioners for hydrocodone, despite the fact that these practitioners were not
 10 legally permitted to prescribe that drug. Additionally, the government alleged that
 11 CVS had recordkeeping deficiencies.¹⁷³

12 284. In May 2015, CVS agreed to pay a \$22 million penalty following a
 13 DEA investigation that found that employees at two pharmacies in Sanford,
 14 Florida, had dispensed prescription opioids, “based on prescriptions that had not
 15 been issued for legitimate medical purposes by a health care provider acting in the
 16 usual course of professional practice. CVS also acknowledged that its retail
 17 pharmacies had a responsibility to dispense only those prescriptions that were
 18 issued based on legitimate medical need.”¹⁷⁴

19

20

21

22 ¹⁷² Press Release, U.S. Attorney’s Office Dist. of Mass., *CVS to Pay \$3.5 Million*
 23 *to Resolve Allegations that Pharmacists Filled Fake Prescriptions*, U.S. Dep’t of
 24 Just. (June 30, 2016), <https://www.justice.gov/usao-ma/pr/cvs-pay-35-million-resolve-allegations-pharmacists-filled-fake-prescriptions>.

25 ¹⁷³ Press Release, U.S. Attorney’s Office Dist. of R.I., Drug Diversion Claims
 26 Against CVS Health Corp. Resolved With \$450,000 Civil Settlement, U.S. Dep’t of
 27 Just. (Aug. 10, 2015), <https://www.justice.gov/usao-ri/pr/drug-diversion-claims-against-cvs-health-corp-resolved-450000-civil-settlement>.

28 ¹⁷⁴ Press Release, U.S. Attorney’s Office M. Dist. of Fla., United States Reaches
 29 \$22 Million Settlement Agreement With CVS For Unlawful Distribution of
 30 Controlled Substances, U.S. Dep’t of Just. (May 13, 2015),
<https://www.justice.gov/usao-mdfl/pr/united-states-reaches-22-million-settlement-agreement-cvs-unlawful-distribution>.

1 285. In September 2014, CVS agreed to pay \$1.9 million in civil penalties
 2 to resolve allegations it filled prescriptions written by a doctor whose controlled-
 3 substance registration had expired.¹⁷⁵

4 286. In August 2013, CVS was fined \$350,000 by the Oklahoma
 5 Pharmacy Board for improperly selling prescription narcotics in at least five
 6 locations in the Oklahoma City metropolitan area.¹⁷⁶

7 287. Dating back to 2006, CVS retail pharmacies in Oklahoma and
 8 elsewhere intentionally violated the CSA by filling prescriptions signed by
 9 prescribers with invalid DEA registration numbers.¹⁷⁷

10 **ii. Walgreens**

11 288. Walgreens is the second-largest pharmacy store chain in the United
 12 States behind CVS, with annual revenue of more than \$118 billion. According to
 13 its website, Walgreens operates more than 8,100 retail locations and filled 990
 14 million prescriptions on a 30-day adjusted basis in fiscal 2017.

15 289. Walgreens also has been penalized for serious and flagrant violations
 16 of the CSA. Indeed, Walgreens agreed to the largest settlement in DEA history—
 17 \$80 million—to resolve allegations that it committed an unprecedented number of
 18 recordkeeping and dispensing violations of the CSA, including negligently
 19 allowing controlled substances such as oxycodone and other prescription
 20 painkillers to be diverted for abuse and illegal black market sales.¹⁷⁸

21
 22

¹⁷⁵ Patrick Danner, *H-E-B, CVS Fined Over Prescriptions*, San Antonio Express-
 23 News (Sept. 5, 2014), <http://www.expressnews.com/business/local/article/H-E-B-CVS-fined-over-prescriptions-5736554.php>.

24 ¹⁷⁶ Andrew Knittle, *Oklahoma pharmacy board stays busy, hands out massive fines at times*, NewsOK (May 3, 2015), <http://newsok.com/article/5415840>.

25 ¹⁷⁷ Press Release, U.S. Attorney's Office W. Dist. of Okla., CVS to Pay \$11
 26 Million To Settle Civil Penalty Claims Involving Violations of Controlled
 27 Substances Act, U.S. Dep't of Just. (Apr. 3, 2013), <https://www.justice.gov/usao-wdok/pr/cvs-pay-11-million-settle-civil-penalty-claims-involving-violations-controlled>.

28 ¹⁷⁸ Press Release, U.S. Attorney's Office S. Dist. of Fla., *Walgreens Agrees To Pay A Record Settlement Of \$80 Million For Civil Penalties Under The Controlled Substances Act*, U.S. Dep't of Just. (June 11, 2013), <https://www.justice.gov/usao-sdfla/pr/walgreens-agrees-pay-record-settlement-civil-penalties-under-controlled-substances-act>.

1 290. The settlement resolved investigations into and allegations of CSA
 2 violations in Florida, New York, Michigan, and Colorado that resulted in the
 3 diversion of millions of opioids into illicit channels.

4 291. Walgreens' Florida operations at issue in this settlement highlight its
 5 egregious conduct regarding diversion of prescription opioids. Walgreens' Florida
 6 pharmacies each allegedly ordered more than one million dosage units of
 7 oxycodone in 2011—more than ten times the average amount.¹⁷⁹

8 292. They increased their orders over time, in some cases as much as
 9 600% in the space of just two years, including, for example, supplying a town of
 10 3,000 with 285,800 orders of oxycodone in a one-month period. Yet Walgreens
 11 corporate officers turned a blind eye to these abuses. In fact, corporate attorneys
 12 at Walgreens suggested, in reviewing the legitimacy of prescriptions coming from
 13 pain clinics, that “if these are legitimate indicators of inappropriate prescriptions
 14 perhaps we should consider not documenting our own potential noncompliance,”
 15 underscoring Walgreens’ attitude that profit outweighed compliance with the CSA
 16 or the health of communities.¹⁸⁰

17 293. Defendant Walgreens’ settlement with the DEA stemmed from the
 18 DEA’s investigation into Walgreens’ distribution center in Jupiter, Florida, which
 19 was responsible for significant opioid diversion in Florida. According to the Order
 20 to Show Cause, Defendant Walgreens’ corporate headquarters pushed to increase
 21 the number of oxycodone sales to Walgreens’ Florida pharmacies, and provided
 22 bonuses for pharmacy employees based on number of prescriptions filled at the
 23 pharmacy in an effort to increase oxycodone sales. In July 2010, Defendant
 24

25
 26 sdfl/pr/walgreens-agrees-pay-record-settlement-80-million-civil-penalties-under-
 27 controlled.

28 ¹⁷⁹ Order to Show Cause and Immediate Suspension of Registration, *In the Matter of Walgreens Co.* (Drug Enf’t Admin. Sept. 13, 2012).

¹⁸⁰ *Id.*

1 Walgreens ranked all of its Florida stores by number of oxycodone prescriptions
 2 dispensed in June of that year, and found that the highest-ranking store in
 3 oxycodone sales sold almost 18 oxycodone prescriptions per day. All of these
 4 prescriptions were filled by the Jupiter Center.¹⁸¹

5 294. Walgreens has also settled with a number of state attorneys general,
 6 including West Virginia (\$575,000) and Massachusetts (\$200,000).¹⁸²

7 295. The Massachusetts Attorney General's Medicaid Fraud Division
 8 found that, from 2010 through most of 2015, multiple Walgreens stores across the
 9 state failed to monitor the opioid use of some Medicaid patients who were
 10 considered high-risk.

11 296. In January 2017, an investigation by the Massachusetts Attorney
 12 General found that some Walgreens pharmacies failed to monitor patients' drug
 13 use patterns and didn't use sound professional judgment when dispensing opioids
 14 and other controlled substances—despite the context of soaring overdose deaths in
 15 Massachusetts. Walgreens agreed to pay \$200,000 and follow certain procedures
 16 for dispensing opioids.¹⁸³

17 iii. Rite Aid

18 297. With approximately 4,600 stores in 31 states and the District of
 19 Columbia, Rite Aid is the largest drugstore chain on the East Coast and the third-
 20 largest in the United States, with annual revenue of more than \$21 billion.

21 298. In 2009, as a result of a multi-jurisdictional investigation by the DOJ,
 22 Rite Aid and nine of its subsidiaries in eight states were fined \$5 million in civil
 23 penalties for its violations of the CSA.¹⁸⁴

24
 25 ¹⁸¹ *Id.*

26 ¹⁸² *Walgreens to pay \$200,000 settlement for lapses with opioids*, APhA (Jan. 25,
 27 2017), <https://www.pharmacist.com/article/walgreens-pay-200000-settlement-lapses-opioids>.

28 ¹⁸³ *Id.*

29 ¹⁸⁴ Press Release, Dep't of Just., *Rite Aid Corporation and Subsidiaries Agree to Pay \$5 Million in Civil Penalties to Resolve Violations in Eight States of the*

1 299. The investigation revealed that from 2004 onwards, Rite Aid
2 pharmacies across the country had a pattern of non-compliance with the
3 requirements of the CSA and federal regulations that led to the diversion of
4 prescription opioids in and around the communities of the Rite Aid pharmacies
5 investigated. Rite Aid also failed to notify the DEA of losses of controlled
6 substances in violation of 21 USC 842(a)(5) and 21 C.F.R 1301.76(b).¹⁸⁵

7 300. Numerous state and federal drug diversion prosecutions have
8 occurred in which prescription opioid pills were procured from National Retail
9 Pharmacies. The allegations in this Complaint do not attempt to identify all these
10 prosecutions, and the information above is merely by way of example.

11 301. The litany of state and federal actions against the National Retail
12 Pharmacies demonstrate that they routinely, and as a matter of standard operating
13 procedure, violated their legal obligations under the CSA and other laws and
14 regulations that govern the distribution and dispensing of prescription opioids.

15 302. Throughout the country and the State, the National Retail Pharmacies
16 were or should have been aware of numerous red flags of potential suspicious
17 activity and diversion.

18 303. On information and belief, from the catbird seat of their retail
19 pharmacy operations, the National Retail Pharmacies knew or reasonably should
20 have known about the disproportionate flow of opioids into California and the
21 operation of “pill mills” that generated opioid prescriptions that, by their quantity
22 or nature, were red flags for if not direct evidence of illicit supply and diversion.
23 Additional information was provided by news reports, and state and federal
24 regulatory actions, including prosecutions of pill mills in the area.

25
26
27

Controlled Substances Act, U.S. Dep’t of Just. (Jan. 12, 2009),
28 https://www.justice.gov/opa/pr/rite-aid-corporation-and-subsidiaries-agree-pay-5-million-civil-penalties-resolve-violations.

¹⁸⁵ *Id.*

1 304. On information and belief, the National Retail Pharmacies knew or
2 reasonably should have known about the devastating consequences of the
3 oversupply and diversion of prescription opioids, including spiking opioid
4 overdose rates in the community.

5 305. On information and belief, because of (among others sources of
6 information) regulatory and other actions taken against the National Retail
7 Pharmacies directly, actions taken against others pertaining to prescription opioids
8 obtained from their retail stores, complaints and information from employees and
9 other agents, and the massive volume of opioid prescription drug sale data that
10 they developed and monitored, the National Retail Pharmacies were well aware
11 that their distribution and dispensing activities fell far short of legal requirements.

12 306. The National Retail Pharmacies' actions and omission in failing to
13 effectively prevent diversion and failing to monitor, report, and prevent suspicious
14 orders have contributed significantly to the opioid crisis by enabling, and failing
15 to prevent, the diversion of opioids.

16 **D. THE MANUFACTURER DEFENDANTS' UNLAWFUL FAILURE**
17 **TO PREVENT DIVERSION AND MONITOR, REPORT, AND**
18 **PREVENT SUSPICIOUS ORDERS.**

19 307. The same legal duties to prevent diversion, and to monitor, report,
20 and prevent suspicious orders of prescription opioids that were incumbent upon
21 the Distributor Defendants were also legally required of the Manufacturer
22 Defendants under federal law.

23 308. Under federal law, the Manufacturing Defendants were required to
24 comply with the same licensing requirements and with the same rules regarding
25 prevention of diversion and reporting suspicious orders, as set out above.

26 309. Like the Distributor Defendants, the Manufacturer Defendants were
27 required to register with the DEA to manufacture schedule II controlled
28

1 substances, like prescription opioids. *See* 21 U.S.C. § 823(a). A requirement of
 2 such registration is the:

3 maintenance of effective controls against diversion of particular
 4 controlled substances and any controlled substance in schedule I or II
 5 compounded therefrom into other than legitimate medical, scientific,
 6 research, or industrial channels, by limiting the importation and bulk
 7 manufacture of such controlled substances to a number of
 establishments which can produce an adequate and uninterrupted
 supply of these substances under adequately competitive conditions
 for legitimate medical, scientific, research, and industrial purposes . . .
 .

8 21 U.S.C. § 823(a)(1) (emphasis added).

9 310. Additionally, as “registrants” under Section 823, the Manufacturer
 10 Defendants were also required to monitor, report, and prevent suspicious orders of
 11 controlled substances:

12 The registrant shall design and operate a system to disclose to the
 13 registrant suspicious orders of controlled substances. The registrant
 14 shall inform the Field Division Office of the Administration in his
 area of suspicious orders when discovered by the registrant.
 Suspicious orders include orders of unusual size, orders deviating
 substantially from a normal pattern, and orders of unusual frequency.

15 21 C.F.R. § 1301.74. *See also* 21 C.F.R. § 1301.02 (“Any term used in this part
 16 shall have the definition set forth in section 102 of the Act (21 U.S.C. 802) or part
 17 1300 of this chapter.”); 21 C.F.R. § 1300.01 (“Registrant means any person who is
 18 registered pursuant to either section 303 or section 1008 of the Act (21 U.S.C. 823
 19 or 958).” Like the Distributor Defendants, the Manufacture Defendants breached
 20 these duties.

21 311. The Manufacturer Defendants had access to and possession of the
 22 information necessary to monitor, report, and prevent suspicious orders and to
 23 prevent diversion. The Manufacturer Defendants engaged in the practice of
 24 paying “chargebacks” to opioid distributors. A chargeback is a payment made by
 25 a manufacturer to a distributor after the distributor sells the manufacturer’s
 26 product at a price below a specified rate. After a distributor sells a manufacturer’s
 27 product to a pharmacy, for example, the distributor requests a chargeback from the
 28 manufacturer and, in exchange for the payment, the distributor identifies to the

1 manufacturer the product, volume and the pharmacy to which it sold the product.
 2 Thus, the Manufacturer Defendants knew – just as the Distributor Defendants
 3 knew – the volume, frequency, and pattern of opioid orders being placed and
 4 filled. The Manufacturer Defendants built receipt of this information into the
 5 payment structure for the opioids provided to the opioid distributors.

6 312. Federal statutes and regulations are clear: just like opioid
 7 distributors, opioid manufacturers are required to “design and operate a system to
 8 disclose . . . suspicious orders of controlled substances” and to maintain “effective
 9 controls against diversion.” 21 C.F.R. § 1301.74; 21 U.S.C. § 823(a)(1).

10 313. The Department of Justice has recently confirmed the suspicious
 11 order obligations clearly imposed by federal law upon opioid manufacturers,
 12 fining Mallinckrodt \$35 million for failure to report suspicious orders of
 13 controlled substances, including opioids, and for violating recordkeeping
 14 requirements.¹⁸⁶

15 314. In the press release accompanying the settlement, the Department of
 16 Justice stated: Mallinckrodt “did not meet its obligations to detect and notify DEA
 17 of suspicious orders of controlled substances such as oxycodone, the abuse of
 18 which is part of the current opioid epidemic. These suspicious order monitoring
 19 requirements exist to prevent excessive sales of controlled substances, like
 20 oxycodone Mallinckrodt’s actions and omissions formed a link in the chain
 21 of supply that resulted in millions of oxycodone pills being sold on the street. . . .
 22 ‘Manufacturers and distributors have a crucial responsibility to ensure that
 23 controlled substances do not get into the wrong hands. . . .’”¹⁸⁷

24
 25
 26 ¹⁸⁶ See Press Release, U.S. Dep’t of Justice, Mallinckrodt Agrees to Pay Record
 27 \$35 Million Settlement for Failure to Report Suspicious Orders of Pharmaceutical
 28 Drugs and for Recordkeeping Violations (July 11, 2017),
<https://www.justice.gov/opa/pr/mallinckrodt-agrees-pay-record-35-million-settlement-failure-report-suspicious-orders>.

29 ¹⁸⁷ *Id.* (quoting DEA Acting Administrator Chuck Rosenberg).

1 315. Among the allegations resolved by the settlement, the government
 2 alleged “Mallinckrodt failed to design and implement an effective system to detect
 3 and report ‘suspicious orders’ for controlled substances – orders that are unusual
 4 in their frequency, size, or other patterns . . . [and] Mallinckrodt supplied
 5 distributors, and the distributors then supplied various U.S. pharmacies and pain
 6 clinics, an increasingly excessive quantity of oxycodone pills without notifying
 7 DEA of these suspicious orders.”¹⁸⁸

8 316. The Memorandum of Agreement entered into by Mallinckrodt
 9 (“2017 Mallinckrodt MOA”) avers “[a]s a registrant under the CSA, Mallinckrodt
 10 had a responsibility to maintain effective controls against diversion, including a
 11 requirement that it review and monitor these sales and report suspicious orders to
 12 DEA.”¹⁸⁹

13 317. The 2017 Mallinckrodt MOA further details the DEA’s allegations
 14 regarding Mallinckrodt’s failures to fulfill its legal duties as an opioid
 15 manufacturer:

16 With respect to its distribution of oxycodone and hydrocodone
 17 products, Mallinckrodt’s alleged failure to distribute these controlled
 18 substances in a manner authorized by its registration and
 19 Mallinckrodt’s alleged failure to operate an effective suspicious order
 20 monitoring system and to report suspicious orders to the DEA when
 21 discovered as required by and in violation of 21 C.F.R. § 1301.74(b).
 22 The above includes, but is not limited to Mallinckrodt’s alleged failure
 23 to:
 24 i. conduct adequate due diligence of its customers;
 25 ii. detect and report to the DEA orders of unusual size and
 26 frequency;
 27 iii. detect and report to the DEA orders deviating substantially
 28 from normal patterns including, but not limited to, those
 29 identified in letters from the DEA Deputy Assistant

26 ¹⁸⁸ *Id.*

27 ¹⁸⁹ Administrative Memorandum of Agreement between the United States
 28 Department of Justice, the Drug Enforcement Agency, and Mallinckrodt, plc. and
 29 its subsidiary Mallinckrodt, LLC (July 10, 2017), <https://www.justice.gov/usao-edmi/press-release/file/986026/download> (“2017 Mallinckrodt MOA”).

Administrator, Office of Diversion Control, to registrants dated September 27, 2006 and December 27, 2007:

- 1 1. orders that resulted in a disproportionate amount of a
2 substance which is most often abused going to a
3 particular geographic region where there was known
4 diversion,
- 5 2. orders that purchased a disproportionate amount of a
6 substance which is most often abused compared to other
7 products, and
- 8 3. orders from downstream customers to distributors who
9 were purchasing from multiple different distributors, of
10 which Mallinckrodt was aware;
- 11 iv. use "chargeback" information from its distributors to evaluate
12 suspicious orders. Chargebacks include downstream
13 purchasing information tied to certain discounts, providing
14 Mallinckrodt with data on buying patterns for Mallinckrodt
15 products; and
- 16 v. take sufficient action to prevent recurrence of diversion by
17 downstream customers after receiving concrete information of
18 diversion of Mallinckrodt product by those downstream
19 customers.¹⁹⁰

20 318. Mallinckrodt agreed that its "system to monitor and detect suspicious
21 orders did not meet the standards outlined in letters from the DEA Deputy
22 Administrator, Office of Diversion Control, to registrants dated September 27,
23 2006 and December 27, 2007." Mallinckrodt further agreed that it "recognizes the
24 importance of the prevention of diversion of the controlled substances they
25 manufacture" and would "design and operate a system that meets the requirements
26 of 21 CFR 1301.74(b) . . . [such that it would] utilize all available transaction
27 information to identify suspicious orders of any Mallinckrodt product. Further,
28 Mallinckrodt agrees to notify DEA of any diversion and/or suspicious
29 circumstances involving any Mallinckrodt controlled substances that Mallinckrodt
30 discovers."¹⁹¹

¹⁹⁰ 2017 Mallinckrodt MOA at 2-3.

¹⁹¹ *Id.* at 3-4.

1 319. Mallinckrodt acknowledged that “[a]s part of their business model
2 Mallinckrodt collects transaction information, referred to as chargeback data, from
3 their direct customers (distributors). The transaction information contains data
4 relating to the direct customer sales of controlled substances to ‘downstream’
5 registrants.” Mallinckrodt agreed that, from this data, it would “report to the DEA
6 when Mallinckrodt concludes that the chargeback data or other information
7 indicates that a downstream registrant poses a risk of diversion.”¹⁹²

8 320. The same duties imposed by federal law on Mallinckrodt were
9 imposed upon all Manufacturer Defendants.

10 321. The same business practices utilized by Mallinckrodt regarding
11 “charge backs” and receipt and review of data from opioid distributors regarding
12 orders of opioids were utilized industry-wide among opioid manufacturers and
13 distributors, including, upon information and belief, the other Manufacturer
14 Defendants.

15 322. Through, *inter alia*, the charge back data, the Manufacturer
16 Defendants could monitor suspicious orders of opioids.

17 323. The Manufacturer Defendants failed to monitor, report, and halt
18 suspicious orders of opioids as required by federal and state law.

19 324. The Manufacturer Defendants’ failures to monitor, report, and halt
20 suspicious orders of opioids were intentional and unlawful.

21 325. The Manufacturer Defendants have misrepresented their compliance
22 with federal and state law.

23 326. The Manufacturer Defendants enabled the supply of prescription
24 opioids to obviously suspicious physicians and pharmacies, enabled the illegal
25 diversion of opioids, aided criminal activity, and disseminated massive quantities
26 of prescription opioids into the black market.

27
28

¹⁹² *Id.* at 5.

1 327. The wrongful actions and omissions of the Manufacturer Defendants
 2 which have caused the diversion of opioids and which have been a substantial
 3 contributing factor to and/or proximate cause of the opioid crisis are alleged in
 4 greater detail in the racketeering allegations below.

5 328. The Manufacturer Defendants' actions and omissions in failing to
 6 effectively prevent diversion and failing to monitor, report, and prevent suspicious
 7 orders have enabled the unlawful diversion of opioids into Plaintiffs' Community.

8 **E. DEFENDANTS' UNLAWFUL CONDUCT AND BREACHES OF
 9 LEGAL DUTIES CAUSED THE HARM ALLEGED HEREIN AND
 10 SUBSTANTIAL DAMAGES.**

11 329. As the Manufacturer Defendants' efforts to expand the market for
 12 opioids increased so have the rates of prescription and sale of their products —
 13 and the rates of opioid-related substance abuse, hospitalization, and death among
 14 the people of the State and the Plaintiffs' Community. The Distributor Defendants
 15 have continued to unlawfully ship these massive quantities of opioids into
 16 communities like the Plaintiffs' Community, fueling the epidemic.

17 330. There is a "parallel relationship between the availability of
 18 prescription opioid analgesics through legitimate pharmacy channels and the
 19 diversion and abuse of these drugs and associated adverse outcomes."¹⁹³

20 331. Opioid analgesics are widely diverted and improperly used, and the
 21 widespread use of the drugs has resulted in a national epidemic of opioid overdose
 22 deaths and addictions.¹⁹⁴

23 332. The epidemic is "directly related to the increasingly widespread
 24 misuse of powerful opioid pain medications."¹⁹⁵

25
 26
 27

¹⁹³ See Richard C. Dart et al., Trends in Opioid Analgesic Abuse and Mortality in
 the United States, 372 N. Eng. J. Med. 241 (2015).

28 ¹⁹⁴ See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—
 Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

1 333. The increased abuse of prescription painkillers along with growing
2 sales has contributed to a large number of overdoses and deaths.¹⁹⁶

3 334. As shown above, the opioid epidemic has escalated in Plaintiffs'
4 Community with devastating effects. Substantial opiate-related substance abuse,
5 hospitalization and death mirrors Defendants' increased distribution of opiates.

6 335. Because of the well-established relationship between the use of
7 prescription opiates and the use of non-prescription opioids, like heroin, the
8 massive distribution of opioids to Plaintiffs' Community and areas from which
9 such opioids are being diverted into Plaintiffs' Community, has caused the
10 Defendant-caused opioid epidemic to include heroin addiction, abuse, and death.

11 336. Prescription opioid abuse, addiction, morbidity, and mortality are
12 hazards to public health and safety in the State and in Plaintiffs' Community.

13 337. Heroin abuse, addiction, morbidity, and mortality are hazards to
14 public health and safety in the State and in Plaintiffs' Community.

15 338. Defendants repeatedly and purposefully breached their duties under
16 state and federal law, and such breaches are direct and proximate causes of, and/or
17 substantial factors leading to, the widespread diversion of prescription opioids for
18 nonmedical purposes into the Plaintiffs' Community.

19 339. The unlawful diversion of prescription opioids is a direct and
20 proximate cause of, and/or substantial factor leading to, the opioid epidemic,
21 prescription opioid abuse, addiction, morbidity and mortality in the State and
22 Plaintiffs' Community. This diversion and the epidemic are direct causes of
23 foreseeable harms incurred by the Plaintiffs and Plaintiffs' Community.

24
25
26¹⁹⁵ See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*,
374 N. Eng. J. Med. 1480 (2016).

27¹⁹⁶ See Press Release, Ctrs. for Disease Control and Prevention, U.S. Dep't of
Health and Human Servs., Prescription Painkiller Overdoses at Epidemic Levels
(Nov. 1, 2011),
https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html.

1 340. Defendants' intentional and/or unlawful conduct resulted in direct
2 and foreseeable, past and continuing, economic damages for which Plaintiffs seek
3 relief, as alleged herein. Plaintiffs also seek the means to abate the epidemic
4 created by Defendants' wrongful and/or unlawful conduct.

5 341. The County seeks economic damages from the Defendants as
6 reimbursement for the costs associated with damage to its property and past
7 efforts to eliminate the hazards to public health and safety.

8 342. Plaintiffs seek economic damages from the Defendants to pay for the
9 cost to permanently eliminate the hazards to public health and safety and abate the
10 temporary public nuisance.

11 343. To eliminate the hazard to public health and safety, and abate the
12 public nuisance, a "multifaceted, collaborative public health and law enforcement
13 approach is urgently needed."¹⁹⁷

14 344. A comprehensive response to this crisis must focus on preventing
15 new cases of opioid addiction, identifying early opioid-addicted individuals, and
16 ensuring access to effective opioid addiction treatment while safely meeting the
17 needs of patients experiencing pain.¹⁹⁸

18 345. These community-based problems require community-based
19 solutions that have been limited by "budgetary constraints at the state and Federal
20 levels."¹⁹⁹

21
22
23

¹⁹⁷ See Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014*, 64 Morbidity & Mortality Wkly. Rep. 1378 (2016), at 1145.

24
25 ¹⁹⁸ See Johns Hopkins Bloomberg School of Public Health, *The Prescription Opioid Epidemic: An Evidence-Based Approach* (G. Caleb Alexander et al. eds., 2015), http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/research/prescription-opioids/JHSPH_OPIOID_EPIDEMIC_REPORT.pdf.

26
27 ¹⁹⁹ See Office of Nat'l Drug Control Policy, Exec. Office of the President, *Epidemic: Responding to America's Prescription Drug Abuse Crisis* (2011), https://www.ncjrs.gov/pdffiles1/ondcp/rx_abuse_plan.pdf.

1 346. Having profited enormously through the aggressive sale, misleading
2 promotion, and irresponsible distribution of opiates, Defendants should be
3 required to take responsibility for the financial burdens their conduct has inflicted
4 upon the Plaintiffs and Plaintiffs' Community.

5 **F. STATUTES OF LIMITATIONS ARE TOLLED AND DEFENDANTS
6 ARE ESTOPPED FROM ASSERTING STATUTES OF
7 LIMITATIONS AS DEFENSES.**

8 **1. Enforcement of a Public Right.**

9 347. No statute of limitation can be pleaded against the Plaintiffs, which
10 seek to enforce strictly public rights.

11 **2. Continuing Conduct.**

12 348. Plaintiffs contend they continue to suffer harm from the unlawful
13 actions by the Defendants.

14 349. The continued tortious and unlawful conduct by the Defendants
15 causes a repeated or continuous injury. The damages have not occurred all at
16 once but have continued to occur and have increased as time progresses. The tort
17 is not completed nor have all the damages been incurred until the wrongdoing
18 ceases. The wrongdoing and unlawful activity by Defendants has not ceased. The
19 public nuisance remains unabated. The conduct causing the damages remains
20 unabated.

21 **3. Equitable Estoppel.**

22 350. To the extent any statute of limitations defense would apply,
23 Defendants are equitably estopped from relying upon a statute of limitations
24 defense because they undertook active efforts to deceive Plaintiffs and to
25 purposefully conceal their unlawful conduct and fraudulently assure the public,
26 including the State, the Plaintiffs, and Plaintiffs' Community, that they were
27 undertaking efforts to comply with their obligations under the state and federal
28 controlled substances laws, all with the goal of protecting their registered

1 manufacturer or distributor status in the State and to continue generating profits.
 2 Notwithstanding the allegations set forth above, the Defendants affirmatively
 3 assured the public, including the State, the Plaintiffs, and Plaintiffs' Community,
 4 that they are working to curb the opioid epidemic.

5 351. For example, a Cardinal Health executive claimed that it uses
 6 "advanced analytics" to monitor its supply chain, and assured the public it was
 7 being "as effective and efficient as possible in constantly monitoring, identifying,
 8 and eliminating any outside criminal activity."²⁰⁰

9 352. Similarly, McKesson publicly stated that it has a "best-in-class
 10 controlled substance monitoring program to help identify suspicious orders," and
 11 claimed it is "deeply passionate about curbing the opioid epidemic in our
 12 country."²⁰¹

13 353. Moreover, in furtherance of their effort to affirmatively conceal their
 14 conduct and avoid detection, the Distributor Defendants, through their trade
 15 associations, HDMA and NACDS, filed an *amicus* brief in *Masters*
 16 *Pharmaceuticals*, which made the following statements:²⁰²

- 17 a. "HDMA and NACDS members not only have statutory and
 18 regulatory responsibilities to guard against diversion of controlled
 19 prescription drugs, but undertake such efforts as responsible
 members of society."
- 20 b. "DEA regulations that have been in place for more than 40 years
 21 require distributors to *report* suspicious orders of controlled
 substances to DEA based on information readily available to them
 (e.g., a pharmacy's placement of unusually frequent or large orders)."
- 22 c. "Distributors take seriously their duty to report suspicious orders,
 23 utilizing both computer algorithms and human review to detect

24
 25 ²⁰⁰ Bernstein et al., *supra*.

26 ²⁰¹ Scott Higham et al., *Drug Industry Hired Dozens of Officials from the DEA as*
 27 *the Agency Tried to Curb Opioid Abuse*, Wash. Post, Dec. 22, 2016,
 28 https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e_story.html.

29 ²⁰² Brief for HDMA and NACDS, 2016 WL 1321983, at *3-4, *25.

1 suspicious orders based on the generalized information that *is*
2 available to them in the ordering process.”

3 d. “A particular order or series of orders can raise red flags because of
4 its unusual size, frequency, or departure from typical patterns with a
5 given pharmacy.”

6 e. “Distributors also monitor for and report abnormal behavior by
7 pharmacies placing orders, such as refusing to provide business
8 contact information or insisting on paying in cash.”

9 Through the above statements made on their behalf by their trade associations,
10 and other similar statements assuring their continued compliance with their legal
11 obligations, the Distributor Defendants not only acknowledged that they
12 understood their obligations under the law, but they further affirmed that their
13 conduct was in compliance with those obligations.

14 354. The Distributor Defendants have also concealed and prevented
15 discovery of information, including data from the ARCOS database that will
16 confirm their identities and the extent of their wrongful and illegal activities.

17 355. The Manufacturer Defendants distorted the meaning or import of
18 studies they cited and offered them as evidence for propositions the studies did not
19 support. The Manufacturer Defendants invented “pseudoaddiction” and promoted
20 it to an unsuspecting medical community. The Manufacturer Defendants provided
21 the medical community with false and misleading information about ineffectual
22 strategies to avoid or control opioid addiction. The Manufacturer Defendants recommended
23 to the medical community that dosages be increased, without
24 disclosing the risks. The Manufacturer Defendants spent millions of dollars over a
25 period of years on a misinformation campaign aimed at highlighting opioids’
26 alleged benefits, disguising the risks, and promoting sales. The medical
27 community, consumers, the State, and Plaintiffs’ Community were duped by the
28 Manufacturer Defendants’ campaign to misrepresent and conceal the truth about
 the opioid drugs that they were aggressively pushing in the State and in Plaintiffs’
 Community.

1 356. Defendants intended that their actions and omissions would be relied
2 upon, including by Plaintiffs and Plaintiffs' Community. Plaintiffs and Plaintiffs'
3 Community did not know, and did not have the means to know, the truth due to
4 Defendants' actions and omissions.

5 357. The Plaintiffs and Plaintiffs' Community reasonably relied on
6 Defendants' affirmative statements regarding their purported compliance with
7 their obligations under the law and consent orders. To the extent statutes of
8 limitations could apply to Plaintiffs' claims, Plaintiffs failed to commence an
9 action within the statutory periods because of reliance on Defendants' wrongful
10 conduct.

11 358. Defendants are estopped from asserting a statute of limitations
12 defense because their conduct and misrepresentations were so unfair and
13 misleading as to outweigh the public's interest in setting limitations on bringing
14 actions.

15 **4. Fraudulent Concealment**

16 359. To the extent any statute of limitations defense would apply,
17 Plaintiffs' claims are further subject to equitable tolling, stemming from
18 Defendants' knowing and fraudulent concealment of the facts alleged herein. As
19 alleged herein, Defendants knew of the wrongful acts set forth above, had material
20 information pertinent to their discovery, and concealed them from the Plaintiffs
21 and Plaintiffs' Community. The Plaintiffs did not know, or could not have known
22 through the exercise of reasonable diligence, of their causes of action, as a result
23 of Defendants' conduct.

24 360. The purposes of the statutes of limitations period, if any, are satisfied
25 because Defendants cannot claim prejudice due to a late filing where the Plaintiffs
26 filed suit promptly upon discovering the facts essential to their claims, described
27 herein, which Defendants knowingly concealed.

28

1 361. In light of their statements to the media, in legal filings and in
2 settlements, it is clear that Defendants had actual or constructive knowledge that
3 their conduct was deceptive, in that they consciously concealed the schemes set
4 forth herein.

5 362. Defendants continually and secretly engaged in their scheme to avoid
6 compliance with their legal obligations. Only Defendants and their agents knew or
7 could have known about Defendants' unlawful actions because Defendants made
8 deliberate efforts to conceal their conduct. As a result of the above, the Plaintiffs
9 were unable to obtain vital information bearing on their claims absent any fault or
10 lack of diligence on their part.

V. LEGAL CAUSES OF ACTION

COUNT I

PUBLIC NUISANCE

(Brought by The People Against all Defendants)

15 363. Plaintiff, The People, incorporate by reference all other paragraphs of
16 this Complaint as if fully set forth here, and further allege as follows.

17 364. Each Defendant is liable for public nuisance because its conduct at
18 issue has caused an unreasonable and substantial interference with a right
19 common to the general public. *See Cty. of Santa Clara v. Atl. Richfield Co.*, 137
20 Cal. App. 4th 292, 305, 40 Cal. Rptr. 3d 313, 325 (2006) (cit. om.). The
21 interference is substantial “if it causes significant harm and unreasonable if its
22 social utility is outweighed by the gravity of the harm inflicted.” *Id.* The causation
23 element of a public nuisance cause of action is satisfied if the defendant’s conduct
24 is a substantial factor in bringing about the result. *People v. Conagra Grocery*
25 *Prod. Co.*, 17 Cal. App. 5th 51, 101-02, 227 Cal. Rptr. 3d 499, 543 (Ct. App.
26 2017), *reh’g denied* (Dec. 6, 2017), *review denied* (Feb. 14, 2018).

365. Under California law, a nuisance is “anything which is injurious to
health, including but not limited to the illegal sale of controlled substances, or is

1 indecent or offensive to the senses, or an obstruction to the free use of property, so
2 as to interfere with the comfortable enjoyment of life or property.” Cal. Civ. Code
3 § 3479.

4 366. California defines a “public nuisance” as “one which affects at the
5 same time an entire community or neighborhood, or any considerable number of
6 persons, although the extent of the annoyance or damage inflicted upon
7 individuals may be unequal.” Cal. Civ. Code § 3480.

8 367. Defendants have created a public nuisance under California law.

9 368. The People have standing to bring this claim to abate the public
10 nuisance due to the opioid epidemic which was created by Defendants and which
11 is affecting and causing harm in Plaintiffs’ Community. *See* Cal. Civ. Proc. Code
12 § 731.

13 369. By causing dangerously addictive drugs to flood the community, and
14 to be diverted for illicit purposes, in contravention of federal and state law, each
15 Defendant has injuriously affected rights common to the general public,
16 specifically including the rights of the people of the Plaintiffs’ Community to
17 public health, public safety, public peace, public comfort, and public convenience.
18 The public nuisance caused by Defendants’ diversion of dangerous drugs has
19 caused substantial annoyance, inconvenience, and injury to the public.

20 370. By selling dangerously addictive opioid drugs diverted from a
21 legitimate medical, scientific, or industrial purpose, Defendants have committed a
22 course of conduct that injuriously affects the safety, health, and morals of the
23 people of the Plaintiffs’ Community.

24 371. By failing to maintain a closed system that guards against diversion
25 of dangerously addictive drugs for illicit purposes, Defendants injuriously affected
26 public rights, including the right to public health, public safety, public peace, and
27 public comfort of the people of the Plaintiffs’ Community.

28

1 372. By affirmatively promoting opioids for use for chronic pain,
2 affirmatively promoting opioids as not addictive, affirmatively fostering a
3 misunderstanding of the signs of addiction and how to reliably identify and safely
4 prescribe opioids to patients predisposed to addiction, affirmatively exaggerating
5 the risks of competing medications like NSAIDs, affirmatively promoting their
6 so-called abuse-deterring opioid formulations and affirmatively identifying and
7 targeting susceptible prescribers and vulnerable patient populations, Defendants
8 injuriously affected public rights, including the right to public health, public
9 safety, public peace, and public comfort of the people of the Plaintiffs'
10 Community. The public nuisance caused by Defendants' affirmative promotion
11 of opioids has caused substantial annoyance, inconvenience, and injury to the
12 public.

13 373. Defendants' interference with the comfortable enjoyment of life in
14 the Plaintiffs' Community is unreasonable because there is little social utility to
15 opioid diversion and abuse, and any potential value is outweighed by the gravity
16 of the harm inflicted by Defendants' actions.

17 374. The People allege that Defendants' wrongful and illegal actions have
18 created a public nuisance. Each Defendant is liable for public nuisance because its
19 conduct at issue has caused an unreasonable and substantial interference with a
20 right common to the general public.

21 375. The Defendants have intentionally and/or unlawfully created a
22 nuisance.

23 376. The residents of Plaintiffs' Community have a common right to be
24 free from conduct that creates an unreasonable jeopardy to the public health,
25 welfare and safety, and to be free from conduct that creates a disturbance and
26 reasonable apprehension of danger to person and property.

27 377. Defendants intentionally, unlawfully, and recklessly manufacture,
28 market, distribute, promote and sell prescription opioids that Defendants know, or

1 reasonably should know, will be diverted, causing widespread distribution of
2 prescription opioids in and/or to Plaintiffs' Community, resulting in addiction and
3 abuse, an elevated level of crime, death and injuries to the residents of Plaintiffs'
4 Community, a higher level of fear, discomfort and inconvenience to the residents
5 of Plaintiffs' Community, and direct costs to Plaintiffs' Community.

6 378. Defendants have unlawfully and/or intentionally caused and
7 permitted dangerous drugs under their control to be diverted such as to injure the
8 Plaintiffs' Community and its residents.

9 379. Defendants have unlawfully and/or intentionally promoted and
10 distributed opioids or caused opioids to be distributed without maintaining
11 effective controls against diversion. Such conduct was illegal. Defendants'
12 failures to maintain effective controls against diversion include Defendants'
13 failure to effectively monitor for suspicious orders, report suspicious orders,
14 and/or stop shipment of suspicious orders.

15 380. Defendants have caused a significant and unreasonable interference
16 with the public health, safety, welfare, peace, comfort and convenience, and
17 ability to be free from disturbance and reasonable apprehension of danger to
18 person or property.

19 381. Defendants' conduct in illegally distributing and selling prescription
20 opioids, or causing such opioids to be distributed and sold, where Defendants
21 know, or reasonably should know, such opioids will be diverted and possessed
22 and/or used illegally in Plaintiffs' Community is of a continuing nature.

23 382. Defendants' actions have been of a continuing nature and have
24 produced a significant effect upon the public's rights, including the public's right
25 to health and safety.

26 383. A violation of any rule or law controlling the distribution of a drug of
27 abuse in Plaintiffs' Community and the State is a public nuisance.

28

1 384. Defendants' distribution of opioids while failing to maintain effective
2 controls against diversion was proscribed by statute and regulation.

3 385. Defendants' ongoing conduct produces an ongoing nuisance, as the
4 prescription opioids that they allow and/or cause to be illegally distributed and
5 possessed in Plaintiffs' Community will be diverted, leading to abuse, addiction,
6 crime, and public health costs.

7 386. Because of the continued use and addiction caused by these illegally
8 distributed opioids, The People will continue to fear for their health, safety and
9 welfare, and will be subjected to conduct that creates a disturbance and reasonable
10 apprehension of danger to person and property.

11 387. Defendants know, or reasonably should know, that their conduct will
12 have an ongoing detrimental effect upon the public health, safety and welfare, and
13 the public's ability to be free from disturbance and reasonable apprehension of
14 danger to person and property.

15 388. Defendants know, or reasonably should know, that their conduct
16 causes an unreasonable and substantial invasion of the public right to health,
17 safety and welfare and the public's ability to be free from disturbance and
18 reasonable apprehension of danger to person and property.

19 389. Defendants are aware, and at a bare minimum certainly should be
20 aware, of the unreasonable interference that their conduct has caused in Plaintiffs'
21 Community. Defendants are in the business of manufacturing, marketing, selling,
22 and distributing prescription drugs, including opioids, which are specifically
23 known to Defendants to be dangerous because *inter alia* these drugs are defined
24 under federal and state law as substances posing a high potential for abuse and
25 severe addiction. *See, e.g.,* 21 U.S.C. § 812 (b)(2). Defendants created an
26 intentional nuisance. Defendants' actions created and expanded the abuse of
27 opioids, drugs specifically codified as constituting severely harmful substances.

28

1 390. Defendants' conduct in promoting, marketing, distributing, and
2 selling prescription opioids which the Defendants know, or reasonably should
3 know, will likely be diverted for non-legitimate, non-medical use, creates a strong
4 likelihood that these illegal distributions of opioids will cause death and injuries to
5 residents in Plaintiffs' Community and otherwise significantly and unreasonably
6 interfere with public health, safety and welfare, and with The People's right to be
7 free from disturbance and reasonable apprehension of danger to person and
8 property.

9 391. It is, or should be, reasonably foreseeable to defendants that their
10 conduct will cause deaths and injuries to residents in Plaintiffs' Community, and
11 will otherwise significantly and unreasonably interfere with public health, safety
12 and welfare, and with the public's right to be free from disturbance and reasonable
13 apprehension of danger to person and property.

14 392. The prevalence and availability of diverted prescription opioids in the
15 hands of irresponsible persons and persons with criminal purposes in Plaintiffs'
16 Community not only causes deaths and injuries, but also creates a palpable
17 climate of fear among residents in Plaintiffs' Community where opioid diversion,
18 abuse, addiction are prevalent and where diverted opioids tend to be used
19 frequently.

20 393. Defendants' conduct makes it easier for persons to divert prescription
21 opioids, constituting a dangerous threat to the public.

22 394. Defendants' actions were, at the least, a substantial factor in opioids
23 becoming widely available and widely used for non-medical purposes. Because of
24 Defendants' affirmative promotion of opioids and special positions within the
25 closed system of opioid distribution, without Defendants' actions, opioid use
26 would not have become so widespread, and the enormous public health hazard of
27 prescription opioid and heroin overuse, abuse, and addiction that now exists
28 would have been averted.

1 395. The presence of diverted prescription opioids in Plaintiffs' 2 Community, and the consequence of prescription opioids having been diverted in 3 Plaintiffs' Community, proximately results in and/or substantially contributes to 4 the creation of significant future costs to The People and to Plaintiffs' Community 5 in order to enforce the law, equip its police force and treat the victims of opioid 6 abuse and addiction.

7 396. Stemming the flow of illegally distributed prescription opioids, and 8 abating the nuisance caused by the illegal flow of opioids, will help to alleviate 9 this problem, save lives, prevent injuries and make Plaintiffs' Community a safer 10 place to live.

11 397. Defendants' conduct is a direct and proximate cause of and/or a 12 substantial contributing factor to opioid addiction and abuse in Plaintiffs' 13 Community, costs that will be borne by Plaintiffs' Community and The People, 14 and a significant and unreasonable interference with public health, safety and 15 welfare, and with the public's right to be free from disturbance and reasonable 16 apprehension of danger to person and property.

17 398. Defendants' conduct constitutes a public nuisance and, if unabated, 18 will continue to threaten the health, safety and welfare of the residents of 19 Plaintiffs' Community, creating an atmosphere of fear and addiction that tears at 20 the residents' sense of well-being and security. The People have a clearly 21 ascertainable right to prospectively abate conduct that perpetuates this nuisance.

22 399. Defendants created an intentional nuisance. Defendants' actions 23 created and expanded the abuse of opioids, which are dangerously addictive, and 24 the ensuing associated plague of prescription opioid and heroin addiction. 25 Defendants knew the dangers to public health and safety that diversion of opioids 26 would create in Plaintiffs' Community; however, Defendants intentionally and/or 27 unlawfully failed to maintain effective controls against diversion through proper 28 monitoring, reporting and refusal to fill suspicious orders of opioids. Defendants

1 intentionally and/or unlawfully distributed opioids or caused opioids to be
2 distributed without reporting or refusing to fill suspicious orders or taking other
3 measures to maintain effective controls against diversion. Defendants
4 intentionally and/or unlawfully continued to ship and failed to halt suspicious
5 orders of opioids, or caused such orders to be shipped. Defendants intentionally
6 and/or unlawfully promoted and marketed opioids in manners they knew to be
7 false and misleading. Such actions were inherently dangerous.

8 400. Defendants knew the prescription opioids have a high likelihood of
9 being diverted. It was foreseeable to Defendants that where Defendants distributed
10 prescription opioids or caused such opioids to be distributed without maintaining
11 effective controls against diversion, including monitoring, reporting, and refusing
12 shipment of suspicious orders, that the opioids would be diverted, and create an
13 opioid abuse nuisance in Plaintiffs' Community.

14 401. Defendants' actions also created a nuisance by acting recklessly,
15 negligently and/or carelessly, in breach of their duties to maintain effective
16 controls against diversion, thereby creating an unreasonable and substantial risk of
17 harm.

18 402. Defendants acted with actual malice because Defendants acted with a
19 conscious disregard for the rights and safety of other persons, and said actions
20 have a great probability of causing substantial harm.

21 403. The public nuisance created, perpetuated and maintained by
22 Defendants can be prospectively abated and further reoccurrence of such harm
23 and inconvenience can be prevented.

24 404. The People further seek to prospectively abate the nuisance created
25 by the Defendants' unreasonable, unlawful, intentional, ongoing, continuing,
26 substantial and persistent actions and omissions and interference with a right
27 common to the public.

28

1 405. Defendants' intentional and unlawful actions and omissions and
2 unreasonable interference with a right common to the public are of a continuing
3 nature.

4 406. The public nuisance created by Defendants' actions is substantial and
5 unreasonable – it has caused and continues to cause significant harm to the
6 community, and the harm inflicted outweighs any offsetting benefit. The
7 staggering rates of opioid and heroin use resulting from the Defendants'
8 abdication of their gate-keeping and diversion prevention duties, and the
9 Manufacturer Defendants' fraudulent marketing activities, have caused harm to
10 the entire community that includes, but is not limited to the following:

- 11 a. The high rates of use leading to unnecessary opioid abuse, addiction,
12 overdose, injuries, and deaths.
- 13 b. Even children have fallen victim to the opioid epidemic. Easy access
14 to prescription opioids made opioids a recreational drug of choice
15 among teenagers. Even infants have been born addicted to opioids
16 due to prenatal exposure, causing severe withdrawal symptoms and
17 lasting developmental impacts.
- 18 c. Even those residents of Plaintiffs' Community who have never taken
19 opioids have suffered from the public nuisance arising from
20 Defendants' abdication of their gate-keeper duties and fraudulent
21 promotions. Many residents have endured and will endure both the
22 emotional and financial costs of caring for loved ones addicted to or
23 injured by opioids, and the loss of companionship, wages, or other
24 support from family members who have used, abused, become
25 addicted to, overdosed on, or been killed by opioids.
- 26 d. The opioid epidemic has increased and will increase health care
27 costs.
- 28 e. Employers have lost and will continue to lose the value of productive
29 and healthy employees.
- 30 f. Defendants' conduct created and continues to create an abundance of
31 drugs available for criminal use and fueled a new wave of addiction,
32 abuse, and injury.
- 33 g. Defendants' dereliction of duties and/or fraudulent misinformation
34 campaign pushing dangerous drugs resulted in a diverted supply of
35 narcotics to sell, and the ensuing demand of addicts to buy them.
36 More prescription opioids sold by Defendants led to more addiction,
37 with many addicts turning from prescription opioids to heroin. People
38 addicted to opioids frequently require increasing levels of opioids,
39 and many are turning to heroin as a foreseeable result.

- h. The diversion of opioids into the secondary, criminal market and the increased number of individuals who abuse or are addicted to opioids has increased and continues to increase the demands on health care services and law enforcement.
 - i. The significant and unreasonable interference with the public rights caused by Defendants' conduct has taxed and continues to tax the human, medical, public health, law enforcement, and financial resources of the Plaintiffs' Community.

407. The People seek all legal and equitable relief as allowed by law, other than such damages disavowed herein, including *inter alia* injunctive relief and expenses to prospectively abate the nuisance.

9 408. Pursuant to California Code of Civil Procedure section 731, The
10 People request an order from the Court on behalf of The People providing for
11 abatement of Defendants' ongoing violations of California Civil Code Sections
12 3479 and 3480, and enjoining Defendants from future violations of California
13 Civil Code Sections 3479 and 3480.

14 409. Each Defendant created or assisted in the creation of the epidemic of
15 opioid use and injury and each Defendant is jointly and severally liable for abating
16 it.

**COUNT II
PUBLIC NUISANCE**

(Brought by The County Against all Defendants)

20 410. Plaintiff, The County, incorporates by reference all other paragraphs
21 of this Complaint as if fully set forth here, and further alleges as follows.

22 411. As set forth above, each Defendant is liable for public nuisance
23 because its conduct at issue has caused an unreasonable and substantial
24 interference with a right common to the general public. *See, e.g., Cty. of Santa*
25 *Clara v. Atl. Richfield Co.*, 137 Cal. App. 4th 292, 305, 40 Cal. Rptr. 3d 313, 325
26 (2006); Cal. Civ. Code §§ 3479; 3480.

27 412. Defendants have created a public nuisance under California law.

1 413. The County has standing to bring this claim for damages incurred to
2 its property by the public nuisance due to the opioid epidemic which was created
3 by Defendants and which is affecting and causing harm to The County. An action
4 can be “brought by any person whose property is injuriously affected, or whose
5 personal enjoyment is lessened by a nuisance, as defined in Section 3479 of the
6 Civil Code, and by the judgment in that action the nuisance may be enjoined or
7 abated as well as damages recovered therefor.” Cal. Civ. Proc. Code § 731.
8 “Where a public entity can show it has a property interest injuriously affected by
9 the nuisance, then, like any other such property holder, it should be able to pursue
10 the full panoply of tort remedies available to private persons.” *Selma Pressure*
11 *Treating Co. v. Osmose Wood Preserving Co.*, 221 Cal. App. 3d 1601, 1616, 271
12 Cal. Rptr. 596, 604 (Ct. App. 1990).

13 414. The County has suffered harm to its property interests that is
14 different from the type of harm suffered by the general public and has incurred
15 substantial costs deriving from having to replace and retrofit its property that has
16 been damaged and is being damaged by Defendants’ intentional, unlawful, and
17 reckless manufacturing, marketing, distribution, promotion and sale of
18 prescription opioids.

19 415. Defendants intentionally, unlawfully, and recklessly manufacture,
20 market, distribute, promote and sell prescription opioids that Defendants know, or
21 reasonably should know, will be diverted, causing widespread distribution of
22 prescription opioids in and/or to Plaintiffs’ Community, resulting in The County
23 having to repair and remake its infrastructure, property and systems that have been
24 damaged by Defendants’ action, including, *inter alia*, its property and systems to
25 treat addiction and abuse, to respond to and manage an elevated level of
26 emergencies and crime, and to respond to and treat injuries and process deaths in
27 Plaintiffs’ Community.

28

1 416. The County owns property which has been injuriously affected by the
2 public nuisance caused by Defendants. These property interests, include, *inter*
3 *alia*, additional naloxone doses – The County owns these doses which have been
4 and are destroyed when The County has to administer them to persons who are
5 overdosing as a result of Defendants' intentional, unlawful, and reckless
6 manufacturing, marketing, distribution, promotion and sale of prescription
7 opioids. The County's emergency response system and medical services
8 equipment and other materials will similarly need to be improved and replaced
9 because this property has been and is being damaged due to persons who are
10 overdosing as a result of Defendants' intentional, unlawful, and reckless
11 manufacturing, marketing, distribution, promotion and sale of prescription
12 opioids. The County also has damage to its property related to evidence gathering
13 and testing for the prosecution of drug related crimes.

14 417. In addition, The County has suffered damages to its infrastructure,
15 which will need to be retrofitted and repaired as a result of Defendants'
16 intentional, unlawful, and reckless manufacturing, marketing, distribution,
17 promotion and sale of prescription opioids. This damage includes damage to its
18 law enforcement, medical and rehabilitation infrastructures and systems which are
19 now inadequate to handle the new undue burden on these systems caused by
20 Defendants' conduct. This includes, *inter alia*, repairing and upgrading jail
21 facilities to add additional jail space and beds for opioid addicts who commit
22 crimes as well as retrofitting the facilities to treat inmates' addictions. This also
23 includes repairing and upgrading court systems for prosecution and defense of
24 drug-related crimes. This also includes repairing and upgrading hospital and
25 treatment facilities for members of Plaintiffs' Community addicted to opioids as
26 well as property that is part of and used by The County's Department of the
27 Medical Examiner which must investigate deaths known or suspected to be due to
28 drug intoxication.

1 418. The County owns, operates, manages, maintains, and otherwise has
2 property interests in, all of which have been injured, damaged, or affected by
3 Defendants, the following property:

- 4 a. County Jail system, including buildings, cells, beds, supplies,
5 resources, materials, personnel, equipment, and other property.
- 6 b. County Probation system, including offices, personnel, supplies,
7 resources, materials, equipment, and other property.
- 8 c. County District Attorney system, including offices, personnel,
9 supplies, resources, materials, equipment, and other property.
- 10 d. County Health and Human Services system, including offices,
11 personnel, supplies, resources, materials, equipment, and other
12 property.
- 13 e. County Sheriff and Law Enforcement systems, including Narcan,
14 naloxone, offices, personnel, supplies, resources, materials,
15 equipment, and other property.
- 16 f. County Emergency Responder system, including equipment, Narcan,
17 naloxone, materials, supplies, personnel, offices, and other property.
- 18 g. County Public Health system, including offices, personnel, resources,
19 supplies, equipment, materials, and other property.
- 20 h. County Medical Examiner system, including personnel, offices,
21 supplies, equipment, materials, resources, and other property.
- 22 i. County Public Defender System, including personnel, offices,
23 supplies, equipment, materials, resources, and other property.

24 419. As set forth above in allegations specifically incorporated herein, by
25 selling dangerously addictive opioid drugs diverted from a legitimate medical,
26 scientific, or industrial purpose, Defendants have committed a course of conduct
27 that injuriously affects The County and its property.

1 420. The public nuisance caused by Defendants' affirmative promotion of
2 opioids has caused substantial annoyance, inconvenience, and injury to The
3 County and The County's property.

4 421. The acts by Defendants which have injured The County and its
5 property are unreasonable because there is little social utility to opioid diversion
6 and abuse, and any potential value is outweighed by the gravity of the harm
7 inflicted by Defendants' actions.

8 422. Defendants have unlawfully and/or intentionally caused and
9 permitted dangerous drugs under their control to be diverted such as to injure the
10 County's property.

11 423. Defendants' conduct in illegally distributing and selling prescription
12 opioids, or causing such opioids to be distributed and sold, where Defendants
13 know, or reasonably should know, such opioids will be diverted and possessed
14 and/or used illegally in Plaintiffs' Community is of a continuing nature and has
15 produced a significant injury to The County and its property.

16 424. Defendants' ongoing conduct produces an ongoing nuisance.

17 425. Defendants know, or reasonably should know, that their conduct will
18 have an ongoing detrimental effect upon The County and The County's property.

19 426. Defendants' actions were, at the least, a substantial factor causing the
20 harm to The County and its property.

21 427. The presence of diverted prescription opioids in Plaintiffs'
22 Community, and the consequence of prescription opioids having been diverted in
23 Plaintiffs' Community, proximately results in and/or substantially contributes to
24 the creation of significant past and future costs to The County as it must repair and
25 retrofit its property in order to enforce the law and treat the victims of opioid
26 abuse and addiction.

27

28

1 428. Defendants' conduct is a direct and proximate cause of and/or a
2 substantial contributing factor to opioid addiction and abuse in Plaintiffs'
3 Community, costs that will be borne by Plaintiffs' Community and The County.

4 429. As a direct and proximate result of Defendants' creation of a public
5 nuisance, The County has suffered and continues to suffer damages to its property
6 requiring investigation, repair, remediation, and other costs to be determined at
7 trial.

8 430. The damages available to The County include, *inter alia*, recoupment
9 of governmental costs, flowing from the damages to The County's property which
10 The County seeks to recover damages for. Defendants' conduct is ongoing and
11 persistent, and The County seeks all damages flowing from Defendants' conduct.

12 431. As a direct result of Defendants' conduct, The County and Plaintiffs'
13 Community have suffered actual injury and damages including, but not limited to,
14 significant expenses for repairing and retrofitting property related to police,
15 emergency, health, prosecution, corrections and other services. The County here
16 seeks recovery for its own harm.

17 432. The County has sustained specific and special injuries because its
18 damages include, *inter alia*, injury to the property and systems of its health
19 services, law enforcement, and medical examiner, as well as property costs related
20 to opioid addiction treatment and overdose prevention, as described in this
21 Complaint.

22 433. The County seeks all legal and equitable relief as allowed by law,
23 including *inter alia* compensatory damages, from the Defendants for the creation
24 of a public nuisance, attorney fees and costs, and pre- and post-judgment interest.
25
26
27
28

COUNT III
RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT
18 U.S.C. § 1961, et seq.
(Against Defendants Purdue, Cephalon, Janssen, and Endo)
(The “Opioid Marketing Enterprise”)

434. Plaintiff, The County, incorporates by reference all other paragraphs of this Complaint as if fully set forth herein, and further alleges as follows.

435. Plaintiff, The County, brings this Count on behalf of itself against the following Defendants, as defined above: Purdue, Cephalon, Janssen, and Endo (referred to collectively for this Claim as the “RICO Marketing Defendants”).

436. At all relevant times, the RICO Marketing Defendants were and are “persons” under 18 U.S.C. § 1961(3) because they are entities capable of holding, and do hold, “a legal or beneficial interest in property.”

437. Section 1962(c) of RICO makes it unlawful "for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. § 1962(c).

438. The term “enterprise” is defined as including “any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity.” 18 U.S.C. § 1961(4). The definition of “enterprise” in Section 1961(4) includes legitimate and illegitimate enterprises within its scope. Specifically, the section “describes two separate categories of associations that come within the purview of an ‘enterprise’ -- the first encompassing organizations such as corporations, partnerships, and other ‘legal entities,’ and the second covering ‘any union or group of individuals associated in fact although not a legal entity.’” *United States v. Turkette*, 452 U.S. 576, 577 (1981).

1 439. Beginning in the early 1990s, the RICO Marketing Defendants
2 aggressively sought to bolster their revenue, increase profit, and grow their share
3 of the prescription painkiller market by unlawfully increasing the volume of
4 opioids they sold. The RICO Marketing Defendants knew that they could not
5 increase their profits without misrepresenting that opioids were non-addictive and
6 safe for the long-term treatment of chronic pain.

7 440. The generally accepted standards of medical practice prior to the
8 1990s dictated that opioids should only be used in short durations to treat acute
9 pain, pain relating to recovery from surgery, or for cancer or palliative (end-of-
10 life) care. Due to the evidence of addiction and lack of evidence indicating that
11 opioids improved patients' ability to overcome pain and function, the use of
12 opioids for chronic pain was discouraged or prohibited. As a result, doctors
13 generally did not prescribe opioids for chronic pain.

14 441. Knowing that their products were highly addictive, ineffective and
15 unsafe for the treatment of long-term chronic pain, non-acute and non-cancer pain,
16 the RICO Marketing Defendants formed an association-in-fact enterprise and
17 engaged in a scheme to unlawfully increase their profits and sales, and grow their
18 share of the prescription painkiller market, through repeated and systematic
19 misrepresentations about the safety and efficacy of opioids for treating long-term
20 chronic pain.

21 442. The RICO Marketing Defendants formed an association-in-fact
22 enterprise consisting of “advocacy groups and professional societies” (“Front
23 Groups”) and paid “physicians affiliated with these groups” (KOLs”) in order to
24 unlawfully increase the demand for opioids. Through their personal relationships,
25 the RICO Marketing Defendants and members of the Opioid Marketing Enterprise
26 had the opportunity to form and take actions in furtherance of the Opioid
27 Marketing Enterprise’s common purpose. The RICO Marketing Defendants’
28

1 substantial financial contribution to the Opioid Marketing Enterprise, and the
 2 advancement of opioids-friendly messaging, fueled the U.S. opioids epidemic.²⁰³

3 443. The RICO Marketing Defendants, through the Opioid Marketing
 4 Enterprise, made misleading statements and misrepresentations about opioids that
 5 downplayed the risk of addiction and exaggerated the benefits of opioid use,
 6 including: (1) downplaying the serious risk of addiction; (2) creating and
 7 promoting the concept of “pseudoaddiction” when signs of actual addiction began
 8 appearing and advocated that the signs of addiction should be treated with more
 9 opioids; (3) exaggerating the effectiveness of screening tools to prevent addiction;
 10 (4) claiming that opioid dependence and withdrawal are easily managed; (5)
 11 denying the risks of higher opioid dosages; and (6) exaggerating the effectiveness
 12 of “abuse-deterrant” opioid formulations to prevent abuse and addiction.

13 444. The RICO Marketing Defendants also falsely touted the benefits of
 14 long-term opioid use, including the supposed ability of opioids to improve
 15 function and quality of life, even though there was no scientifically reliable
 16 evidence to support the RICO Marketing Defendants’ claims.

17 445. The RICO Marketing Defendants’ scheme, and the common purpose
 18 of the Opioid Marketing Enterprise, has been wildly successful. Opioids are now
 19 the most prescribed class of drugs. Globally, opioid sales generated \$11 billion in
 20 revenue for drug companies in 2010 alone; sales in the United States have
 21 exceeded \$8 billion in revenue annually since 2009.²⁰⁴ In an open letter to the
 22 nation’s physicians in August 2016, the then-U.S. Surgeon General expressly
 23

24 203 *Fueling an Epidemic: Exposing the Financial Ties Between Opioid*
 25 *Manufacturers and Third Party Advocacy Groups*, U.S. Senate Homeland Security
 & Governmental Affairs Committee, Ranking Members’ Office, February 12,
 2018 <https://www.hsdl.org/?abstract&did=808171> (“*Fueling an Epidemic*”), at 1.

26 204 See Katherine Eban, *OxyContin: Purdue Pharma’s Painful Medicine*, Fortune,
 27 Nov. 9, 2011, <http://fortune.com/2011/11/09/oxycontin-purdue-pharmas-painful-medicine/>; David Crow, *Drugmakers Hooked on \$10bn Opioid Habit*, Fin. Times, Aug. 10, 2016, <https://www.ft.com/content/f6e989a8-5dac-11e6-bb77-a121aa8abd95>.

1 connected this “urgent health crisis” to “heavy marketing of opioids to doctors . . .
 2 [m]any of [whom] were even taught – incorrectly – that opioids are not addictive
 3 when prescribed for legitimate pain.”²⁰⁵

4 446. The scheme devised and implemented by the RICO Marketing
 5 Defendants amounted to a common course of conduct designed to ensure that the
 6 RICO Marketing Defendants unlawfully increased their sales and profits through
 7 misrepresentations about the addictive nature and effective use of the RICO
 8 Marketing Defendants’ drugs. As Senator McCaskill aptly recognized:

9 The opioid epidemic is the direct result of a calculated marketing and
 10 sales strategy developed in the 90’s, which delivered three simple
 11 messages to physicians. First, that chronic pain was severely
 12 undertreated in the United States. Second, that opioids were the best
 13 tool to address that pain. And third, that opioids could treat pain
 14 without risk of serious addiction. As it turns out, these messages were
 15 exaggerations at best and outright lies at worst.²⁰⁶

16 A. THE OPIOID MARKETING ENTERPRISE

17 447. The Opioid Marketing Enterprise consists of the RICO Marketing
 18 Defendants, the Front Groups, and the KOLs – each of whom is identified below:

- 19 • The RICO Defendants
 - 20 ○ Purdue
 - 21 ○ Cephalon
 - 22 ○ Janssen
 - 23 ○ Endo
- 24 • The Front Groups
 - 25 ○ American Pain Foundation (“APF”)
 - 26 ○ American Academy of Pain Medicine (“AAPM”)
 - 27 ○ American Pain Society (“APS”)

28 ²⁰⁵ Letter from Vivek H. Murthy, U.S. Surgeon General (Aug. 2016),
<http://turnthetiderx.org/>; *Fueling An Epidemic*, *supra* n.3, at 1.

²⁰⁶ See, *LIVESTREAM: Insys Opioid Sales and Marketing Practices Roundtable*, September 12, 2017, at 31:03-31:37,
https://www.youtube.com/watch?v=k9mrQa8_vAo (accessed on March 1, 2018).

- 1 ○ Federation of State Medical Boards (“FSMB”)
- 2 ○ U.S. Pain Foundation (“USPF”)
- 3 ○ American Geriatrics Society (“AGS”)
- 4 • The KOLs
 - 5 ○ Dr. Russell Portenoy (“Dr. Portenoy”)
 - 6 ○ Dr. Lynn Webster (“Dr. Webster”)
 - 7 ○ Dr. Perry Fine (“Dr. Fine”)
 - 8 ○ Dr. Scott M. Fishman (“Dr. Fishman”))

9

10 448. The Opioid Marketing Enterprise is an ongoing and continuing
11 business organization that created and maintained systematic links, interpersonal
12 relationships and engaged in a pattern of predicate acts (i.e. racketeering activity)
13 in order to further the common purpose of the enterprise: unlawfully increasing
14 profits and revenues from the continued prescription and use of opioids for long-
15 term chronic pain. Each of the individuals and entities who formed the Opioid
16 Marketing Enterprise is an entity or person within the meaning of 18 U.S.C. §
17 1961(3) and acted to enable the common purpose and fraudulent scheme of the
18 Opioid Marketing Enterprise.

19 449. In order to accomplish the common purpose, members of the Opioid
20 Marketing Enterprise repeatedly and systematically misrepresented –
21 affirmatively, and through half-truths and omissions – that opioids are non-
22 addictive and safe for the effective treatment of long-term, chronic, non-acute and
23 non-cancer pain, and for other off-label uses not approved by the FDA. The
24 Opioid Marketing Enterprise misrepresented and concealed the serious risks and
25 lack of corresponding benefits of using opioids for long-term chronic pain. By
26 making these misrepresentations, the Opioid Marketing Enterprise ensured that a
27 large number of opioid prescriptions would be written and filled for chronic pain.

1 450. At all relevant times, the Opioid Marketing Enterprise: (a) had an
2 existence separate and distinct from each RICO Marketing Defendant and its
3 members; (b) was separate and distinct from the pattern of racketeering in which
4 the RICO Defendants engaged; (c) was an ongoing and continuing organization
5 consisting of individuals, persons, and legal entities, including each of the RICO
6 Marketing Defendants; (d) was characterized by interpersonal relationships
7 between and among each member of the Opioid Marketing Enterprise, including
8 between the RICO Marketing Defendants and each of the Front Groups and
9 KOLs; (e) had sufficient longevity for the enterprise to pursue its purpose; and (f)
10 functioned as a continuing unit.

11 451. The persons and entities engaged in the Opioid Marketing Enterprise
12 are systematically linked through contractual relationships, financial ties, personal
13 relationships, and continuing coordination of activities, as spearheaded by the
14 RICO Marketing Defendants.

15 452. Each of the RICO Marketing Defendants, and each member of the
16 Opioid Marketing Enterprise had systematic links to and personal relationships
17 with each other through joint participation in lobbying groups, trade industry
18 organizations, contractual relationships and continuing coordination of activities.
19 Each of the RICO Marketing Defendants coordinated their marketing efforts
20 through the same KOLs and Front Groups, based on their agreement and
21 understanding that the Front Groups and KOLs were industry friendly and would
22 work together with the RICO Marketing Defendants to advance the common
23 purpose of the Opioid Marketing Enterprise.

24 **1. The RICO Defendants**

25 453. In addition to their systematic links to and personal relationships with
26 the Front Groups and KOLS, described below, the RICO Marketing Defendants
27 had systematic links to and personal relationships with each other through their
28 participation in lobbying groups, trade industry organizations, contractual

1 relationships and continuing coordination of activities, including but not limited
 2 to, the Pain Care Forum (“PCF”) and the Healthcare Distribution Alliance
 3 (“HDA”).

4 454. The PCF has been described as a coalition of drug makers, trade
 5 groups and dozens of non-profit organizations supported by industry funding.
 6 Plaintiffs are informed and believe that the PCF was created with the stated goal
 7 of offering a “setting where multiple organizations can share information” and
 8 “promote and support taking collaborative action regarding federal pain policy
 9 issues.” Plaintiffs are informed and believe that past APF President Will Rowe
 10 described the PCF as “a deliberate effort to positively merge the capacities of
 11 industry, professional associations, and patient organizations.”

12 455. The PCF recently became a national news story when it was
 13 discovered that lobbyists for members of the PCF, including the RICO Marketing
 14 Defendants, quietly shaped federal and state policies regarding the use of
 15 prescription opioids for more than a decade.

16 456. The Center for Public Integrity and The Associated Press obtained
 17 “internal documents shed[ding] new light on how drug makers and their allies
 18 shaped the national response to the ongoing wave of prescription opioid abuse.”²⁰⁷
 19 Specifically, PCF members spent over \$740 million lobbying in the nation’s
 20 capital and in all 50 statehouses on an array of issues, including opioid-related
 21 measures.²⁰⁸

22 457. Not surprisingly, each of the RICO Marketing Defendants who stood
 23 to profit from lobbying in favor of prescription opioid use is a member of and/or
 24
 25

26 207 Matthew Perrone, Pro-Painkiller echo chamber shaped policy amid drug
 27 epidemic, The Center for Public Integrity (September 19, 2017, 12:01 a.m.),
 28 <https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic> (emphasis added).

208 *Id.*

1 participant in the PCF.²⁰⁹ In 2012, membership and participating organizations in
 2 the PCF included the HDA (of which all the RICO Defendants are members),
 3 Endo, Purdue, Johnson & Johnson (the parent company for Janssen
 4 Pharmaceuticals), and Teva (the parent company of Cephalon).²¹⁰ Each of the
 5 RICO Marketing Defendants worked together through the PCF to advance the
 6 interests of the Opioid Marketing Enterprise. But, the RICO Marketing
 7 Defendants were not alone, many of the RICO Marketing Defendants' Front
 8 Groups were also members of the PCF, including the American Academy of Pain
 9 Management, the American Pain Foundation, and the American Pain Society.
 10 Upon information and belief, the RICO Marketing Defendants' KOLs were also
 11 members of and participated in the PCF.

12 458. Through the Pain Care Forum, the RICO Marketing Defendants met
 13 regularly and in person to form and take action to further the common purpose of
 14 the Opioid Marketing Enterprise and shape the national response to the ongoing
 15 prescription opioid epidemic.

16 459. Through the HDA – or Healthcare Distribution Alliance – the RICO
 17 Marketing Defendants “strengthen[ed] . . . alliances”²¹¹ and took actions to further
 18 the common purpose of the Opioid Marketing Enterprise.

19 460. Beyond strengthening alliances, the benefits of HDA membership
 20 included the ability to, among other things, “network one on one with
 21 manufacturer executives at HDA’s members-only Business and Leadership
 22 Conference,” “participate on HDA committees, task forces and working groups

24 ²⁰⁹ PAIN CARE FORUM 2012 Meetings Schedule, (last updated December 2011),
 25 <https://assets.documentcloud.org/documents/3108982/PAIN-CARE-FORUM-Meetings-Schedule-amp.pdf> (last visited March 8, 2018).

26 ²¹⁰ *Id.* Upon information and belief, Mallinckrodt became an active member of the
 27 PCF sometime after 2012.

28 ²¹¹ Manufacturer Membership Benefits, Healthcare Distribution Alliance, (accessed on September 14, 2017),
<https://www.healthcaredistribution.org/~media/pdfs/membership/manufacturer-membership-benefits.ashx?la=en> (emphasis added).

1 with peers and trading partners,” and “make connections.”²¹² Clearly,
 2 membership in the HDA was an opportunity to create interpersonal and ongoing
 3 organizational relationships and “alliances” between the RICO Marketing
 4 Defendants.

5 461. The closed meetings of the HDA’s councils, committees, task forces
 6 and working groups provided the RICO Marketing Defendants with the
 7 opportunity to work closely together, confidentially, to develop and further the
 8 common purpose and interests of the Opioid Marketing Enterprise.

9 462. The HDA also offered multiple conferences, including annual
 10 business and leadership conferences through which the RICO Marketing
 11 Defendants had an opportunity to “bring together high-level executives, thought
 12 leaders and influential managers . . . to hold strategic business discussions on the
 13 most pressing industry issues.”²¹³ The HDA and its conferences were significant
 14 opportunities for the RICO Marketing Defendants to interact at the executive level
 15 and form and take actions in furtherance of the common purpose of the Opioid
 16 Marketing Enterprise. It is clear that the RICO Marketing Defendants embraced
 17 this opportunity by attending and sponsoring these events.²¹⁴

18 463. The systematic contacts and personal relationships developed by the
 19 RICO Marketing Defendants through the PCF and the HDA furthered the
 20 common purpose of the Opioid Marketing Enterprise because it allowed the RICO
 21 Marketing Defendants to coordinate the conduct of the Opioid Marketing

22
 23
 24 ²¹² *Id.*

25 ²¹³ Business and Leadership Conference – Information for Manufacturers,
 26 Healthcare Distribution
 27 Alliance<https://www.healthcaredistribution.org/events/2015-business-and-leadership-conference/blc-for-manufacturers> (last accessed on September 14, 2017).

28 ²¹⁴ 2015 Distribution Management Conference and Expo, Healthcare Distribution
Alliance, <https://www.healthcaredistribution.org/events/2015-distribution-management-conference> (last accessed on September 14, 2017).

1 Enterprise by, including but not limited to, coordinating their interaction and
2 development of relationships with the Front Groups and KOLs.

3 **2. The Front Groups**

4 464. Each of the RICO Marketing Defendants had systematic links to and
5 personal relationships with Front Groups that operated as part of the Opioid
6 Marketing Enterprise to further the common purpose of unlawfully increasing
7 sales by misrepresenting the non-addictive and effective use of opioids for the
8 treatment of long-term chronic pain. As recently reported by the U.S. Senate in
9 “*Fueling an Epidemic*”:

10 The fact that these same manufacturers provided millions of dollars to
11 the groups described below suggests, at the very least, a direct link
12 between corporate donations and the advancement of opioids-friendly
13 messaging. By aligning medical culture with industry goals in this
14 way, many of the groups described in this report may have played a
15 significant role in creating the necessary conditions for the U.S.
16 opioids epidemic.²¹⁵

17 465. “Patient advocacy organizations and professional societies like the
18 Front Groups ‘play a significant role in shaping health policy debates, setting
19 national guidelines for patient treatment, raising disease awareness, and educating
20 the public.’²¹⁶ ‘Even small organizations—with ‘their large numbers and
21 credibility with policymakers and the public’—have ‘extensive influence in
22 specific disease areas.’ Larger organizations with extensive funding and outreach
23 capabilities ‘likely have a substantial effect on policies relevant to their industry
24 sponsors.’²¹⁷ Indeed, as reflected below, the U.S. Senate’s report found that the
25 RICO Marketing Defendants made nearly \$9 million worth of contributions to
26 various Front Groups, including members of the Opioid Marketing Enterprise.²¹⁸

26 ²¹⁵ *Fueling an Epidemic*, at p. 1.

27 ²¹⁶ *Id.* at p. 2

28 ²¹⁷ *Id.*

28 ²¹⁸ *Id.* at p. 3.

1 FIGURE 1: Manufacturer Payments to Selected Groups, 2012-2017
2

	Purdue ²²	Janssen ²³	Depomed	Insys	Mylan	Total
Academy of Integrative Pain Management	\$1,091,024.86	\$128,000.00	\$43,491.95	\$3,050.00 ²⁴	\$0.00	\$1,265,566.81
American Academy of Pain Medicine	\$725,584.95	\$83,975.00	\$332,100.00	\$57,750.00	\$0.00	\$1,199,409.95
AAPM Foundation	\$0.00	\$0.00	\$304,605.00	\$0.00	\$0.00	\$304,605.00
ACS Cancer Action Network	\$168,500.00 ²⁵	\$0.00	\$0.00	\$0.00	\$0.00	\$168,500.00
American Chronic Pain Association	\$312,470.00	\$50,000.00	\$54,670.00	\$0.00	\$0.00	\$417,140.00
American Geriatrics Society	\$11,785.00 ²⁶	\$0.00	\$0.00	\$0.00	\$0.00	\$11,785.00
American Pain Foundation	\$25,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25,000.00
American Pain Society	\$542,259.52	\$88,500.00	\$288,750.00	\$22,965.00	\$20,250.00	\$962,724.52
American Society of Pain Educators	\$30,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$30,000.00
American Society of Pain Management Nursing	\$242,535.00	\$55,177.85 ²⁷	\$25,500.00 ²⁸	\$0.00	\$0.00	\$323,212.85
The Center for Practical Bioethics	\$145,095.00	\$18,000.00	\$0.00	\$0.00	\$0.00	\$163,095.00
The National Pain Foundation²⁹	\$0.00	\$0.00	\$0.00	\$562,500.00	\$0.00	\$562,500.00
U.S. Pain Foundation	\$359,300.00	\$41,500.00	\$22,000.00	\$2,500,000.00 ³⁰	\$0.00	\$2,922,800.00
Washington Legal Foundation	\$500,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$500,000.00
	\$4,153,554.33	\$465,152.85	\$1,071,116.95	\$3,146,265.00	\$20,250.00	\$8,856,339.13

23 466. The Front Groups included in the Opioid Marketing Enterprise “have
 24 promoted messages and policies favorable to opioid use while receiving millions
 25 of dollars in payments from opioid manufacturers. Through criticism of
 26 government prescribing guidelines, minimization of opioid addiction risk, and
 27 other efforts, ostensibly neutral advocacy organizations have often supported
 28

1 industry interests at the expense of their own constituencies.²¹⁹ And, as reflected
 2 below, many of the RICO Marketing Defendants' Front Groups received the
 3 largest contributions:

4 FIGURE 5: Group Rankings by Manufacturer Payments, 2012-2017

U.S. Pain Foundation	\$2,922,800.00
Academy of Integrative Pain Management	\$1,265,566.81
American Academy of Pain Medicine	\$1,199,409.95
American Pain Society	\$962,724.52
The National Pain Foundation	\$562,500.00
Washington Legal Foundation	\$500,000.00
American Chronic Pain Association	\$417,140.00
American Society of Pain Management Nursing	\$323,212.85
AAPM Foundation	\$304,605.00
ACS Cancer Action Network	\$168,500.00
The Center for Practical Bioethics	\$163,095.00
American Society of Pain Educators	\$30,000.00
American Pain Foundation	\$25,000.00
American Geriatrics Society	\$11,785.00

15 467. But, the RICO Marketing Defendants connection with and control
 16 over the Front Groups did not end with financial contributions. Rather, the RICO
 17 Marketing Defendants made substantial contributions to physicians affiliated with
 18 the Front Groups totaling more than \$1.6 million.²²⁰ Moreover, the RICO
 19 Marketing Defendants "made substantial payments to individual group executives,
 20 staff members, board members, and advisory board members" affiliated with the
 21 Front Groups subject to the Senate Committee's study.²²¹

22
 23
 24
 25
 26

27 ²¹⁹ *Id.* at p. 3.

28 ²²⁰ *Id.* at p. 3.

²²¹ *Id.* at p. 10.

1 468. As described in more detail below²²², the RICO Marketing
 2 Defendants “amplified or issued messages that reinforce industry efforts to
 3 promote opioid prescription and use, including guidelines and policies minimizing
 4 the risk of addiction and promoting opioids for chronic pain.”²²³ They also
 5 “lobbied to change laws directed at curbing opioid use, strongly criticized
 6 landmark CDC guidelines on opioid prescribing, and challenged legal efforts to
 7 hold physicians and industry executives responsible for overprescription and
 8 misbranding.”²²⁴

9
 10 FIGURE 7: Purdue, Janssen, Insys, Depomed, and Mylan Payments to Groups and Group-
 Affiliated Individuals, 2012-Present⁴¹

	Payments to Group	Payments to Group- Affiliated Individuals	Total
U.S. Pain Foundation	\$2,922,800.00	\$126.20	\$2,922,926.20
The National Pain Foundation	\$562,500.00	\$839,848.84	\$1,402,348.84
Academy of Integrative Pain Management	\$1,265,566.81	\$30,223.42	\$1,295,790.23
American Academy of Pain Medicine	\$1,199,409.95	\$16,462.42	\$1,215,872.37
American Pain Society	\$962,724.52	\$95,474.56	\$1,058,199.08
AAPM Foundation	\$304,605.00	\$314,175.58	\$618,780.58
Washington Legal Foundation	\$500,000.00	N/A	\$500,000.00
American Chronic Pain Association	\$417,140.00	\$31,265.87	\$448,405.87
American Society of Pain Management Nursing	\$323,212.85	N/A	\$323,212.85
American Society of Pain Educators	\$30,000.00	\$280,765.92	\$310,765.92
The Center for Practical Bioethics	\$163,095.00	\$7,116.86	\$170,211.86
ACS Cancer Action Network	\$168,500.00	N/A	\$168,500.00
American Pain Foundation	\$25,000.00	N/A	\$25,000.00
American Geriatrics Society	\$11,785.00	\$194.13	\$11,979.13
Total	\$8,856,339.13	\$1,615,653.80	\$10,471,992.93

25
 26 ²²² The activities that the Front Groups engaged in, and the misrepresentations that
 they made, in furtherance of the common purpose of the Opioid Marketing
 Enterprise are alleged more fully below, under the heading “Conduct of the Opioid
 Marketing Enterprise.”

27
 28 ²²³ *Id.* at 12-15.

224 *Id.* at 12.

1 469. The systematic contacts and interpersonal relationships of the RICO
 2 Marketing Defendants, and the Front Groups are further described below:

3 470. The American Pain Foundation (“APF”) – The American Pain
 4 Foundation was the most prominent member of the RICO Defendants’ Front
 5 Groups and was funded almost exclusively by the RICO Marketing Defendants.
 6 Plaintiffs are informed and believe that APF received more than \$10 million in
 7 funding from the RICO Marketing Defendants between 2007 and the close of its
 8 business in May 2012. The APF had multiple contacts and personal relationships
 9 with the RICO Marketing Defendants through its many publishing and
 10 educational programs, funded and supported by the RICO Marketing Defendants.
 11 Plaintiffs are further informed and believe that between 2009 and 2010, APF
 12 received more than eighty percent (80%) of its operating budget from
 13 pharmaceutical industry sources. Including industry grants for specific projects,
 14 APF received about \$2.3 million from industry sources out of total income of
 15 about \$2.85 million in 2009; its budget for 2010 projected receipts of roughly \$2.9
 16 million from drug companies, out of total income of about \$3.5 million. By 2011,
 17 upon information and belief, APF was entirely dependent on incoming grants
 18 from Defendants Purdue, Cephalon, Endo, and others.

19 471. On information and belief, APF was often called upon to provide
 20 “patient representatives” for the RICO Marketing Defendants’ promotional
 21 activities, including for Purdue’s “Partners Against Pain” and Janssen’s “Let’s
 22 Talk Pain.” APF functioned largely as an advocate for the interests of the RICO
 23 Marketing Defendants, not patients. Indeed, upon information and belief, as early
 24 as 2001, Purdue told APF that the basis of a grant was Purdue’s desire to
 25 “strategically align its investments in nonprofit organizations that share [its]
 26 business interests.”

27 472. APF is also credited with creating the PCF in 2004. Plaintiffs are
 28 informed and believe that the PCF was created with the stated goal of offering a

1 “setting where multiple organizations can share information” and “promote and
 2 support taking collaborative action regarding federal pain policy issues.”
 3 Plaintiffs are informed and believe that past APF President Will Rowe described
 4 the PCF as “a deliberate effort to positively merge the capacities of industry,
 5 professional associations, and patient organizations.”

6 473. Upon information and belief, representatives of the RICO Marketing
 7 Defendants, often at informal meetings at conferences, suggested activities and
 8 publications for APF to pursue. APF then submitted grant proposals seeking to
 9 fund these activities and publications, knowing that drug companies would
 10 support projects conceived as a result of these communications.

11 474. Furthermore, APF’s Board of Directors was largely comprised of
 12 doctors who were on Defendants’ payrolls, either as consultants or speakers at
 13 medical events.²²⁵ As described below, many of the KOLs involved in the Opioid
 14 Marketing Enterprise also served in leadership positions within the APF.

15 475. In December 2011, a ProPublica investigation found that in 2010,
 16 nearly 90% of APF’s funding came from the drug and medical device community,
 17 including RICO Marketing Defendants.²²⁶ More specifically, APF received
 18 approximately \$2.3 million from industry sources out of total income of \$2.85
 19 million in 2009. It’s budget for 2010 projected receipt of approximately \$2.9
 20 million from drug companies, out of total income of approximately \$3.5 million.
 21 In May 2012, the U.S. Senate Finance Committee began looking into APF to
 22 determine the links, financial and otherwise, between the organization and the
 23 manufacturers of opioid painkillers. Within days of being targeted by the Senate
 24

25 ²²⁵ Charles Ornstein and Tracy Weber, *The Champion of Painkillers*, ProPublica
 26 (Dec. 23, 2011), <https://www.propublica.org/article/the-champion-of-painkillers>.

27 ²²⁶ Charles Ornstein & Tracy Weber, *Patient advocacy group funded by success of*
 28 *painkiller drugs, probe finds*, Wash. Post (Dec. 23, 2011),
https://www.washingtonpost.com/national/healthscience/patient-advocacy-group-funded-by-success-of-painkiller-drugs-probefinds/2011/12/20/gIQAvgczDP_story.html?utm_term=.22049984c606.

1 investigation, APF's Board voted to dissolve the organization "due to irreparable
2 economic circumstances." APF "cease[d] to exist, effective immediately."²²⁷

3 476. The American Academy of Pain Medicine ("AAPM") – The AAPM
4 was another Front Group that had systematic ties and personal relationships with
5 the RICO Defendants. AAPM received over \$2.2 million in funding since 2009
6 from opioid manufacturers. AAPM maintained a corporate relations council,
7 whose members paid \$25,000 per year (on top of other funding) to participate.
8 The benefits included allowing members to present educational programs at off-
9 site dinner symposia in connection with AAPM's marquee event – its annual
10 meeting held in Palm Springs, California, or other resort locations. AAPM
11 describes the annual event as an "exclusive venue" for offering education
12 programs to doctors. Membership in the corporate relations council also allowed
13 drug company executives and marketing staff to meet with AAPM executive
14 committee members in small settings. The RICO Marketing Defendants were all
15 members of the council and presented deceptive programs to doctors who
16 attended this annual event.²²⁸

17 477. The RICO Marketing Defendants internally viewed AAPM as
18 "industry friendly," with RICO Defendants' advisors and speakers among its
19 active members. The RICO Marketing Defendants attended AAPM conferences,
20 funded its CMEs and satellite symposia, and distributed its publications. AAPM
21 conferences heavily emphasized sessions on opioids. AAPM presidents have
22 included top industry-supported KOLs like Perry Fine and Lynn Webster.

23
24
25

²²⁷ Charles Ornstein & Tracy Weber, *Senate Panel Investigates Drug Companies' Ties to Pain Groups*, Wash. Post, May 8, 2012, https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU_story.html.

26
27 ²²⁸ The American Academy of Pain Medicine, Pain Medicine DC The Governing Voices of Pain: Medicine, Science, and Government, March 24-27, 2011, <http://www.painmed.org/files/2011-annual-meeting-program-book.pdf>.

1 478. Upon information and belief, representatives of the RICO Marketing
 2 Defendants, often at informal meetings at conferences, suggested activities and
 3 publications for AAPM to pursue. AAPM then submitted grant proposals seeking
 4 to fund these activities and publications, knowing that drug companies would
 5 support projects conceived as a result of these communications.

6 479. Plaintiffs are informed and believe that members of AAPM's Board
 7 of Directors were doctors who were on the RICO Marketing Defendants' payrolls,
 8 either as consultants or speakers at medical events. As described below, many of
 9 the KOLs involved in the Opioid Marketing Enterprise also served in leadership
 10 positions within the AAPM.

11 480. The American Pain Society ("APS") – The APS was another Front
 12 Group with systematic connections and interpersonal relationships with the RICO
 13 Marketing Defendants. APS was one of the Front Groups investigated by
 14 Senators Grassley and Baucus, as evidenced by their May 8, 2012 letter arising
 15 out of their investigation of "extensive ties between companies that manufacture
 16 and market opioids and non-profit organizations" that "helped created a body of
 17 dubious information favoring opioids."²²⁹

18 481. Upon information and belief, representatives of the RICO Marketing
 19 Defendants, often at informal meetings at conferences, suggested activities and
 20 publications for APS to pursue. APS then submitted grant proposals seeking to
 21 fund these activities and publications, knowing that drug companies would
 22 support projects conceived as a result of these communications.

23 482. Plaintiffs are informed and believe that members of APS's Board of
 24 Directors were doctors who were on the RICO Marketing Defendants' payrolls,

26 229 Letter from U.S. Senators Charles E. Grassley and Max Baucus to Catherine
 27 Underwood, Executive Director (May 8, 2012), American Pain Society,
<https://www.finance.senate.gov/imo/media/doc/05092012%20Baucus%20Grassley%20Opioid%20Investigation%20Letter%20to%20American%20Pain%20Society.pdf>.

1 either as consultants or speakers at medical events. As described below, many of
 2 the KOLs involved in the Opioid Marketing Enterprise also served in leadership
 3 positions within the APS.

4 483. The Federation of State Medical Boards (“FSMB”) – FSMB was
 5 another Front Group with systematic connections and interpersonal relationships
 6 with the RICO Marketing Defendants. In addition to the contributions reported in
 7 *Fueling an Epidemic*, a June 8, 2012 letter submitted by FSMB to the Senate
 8 Finance Committee disclosed substantial payments from the RICO Marketing
 9 Defendants beginning in 1997 and continuing through 2012.²³⁰ Not surprisingly,
 10 the FSMB was another one of the Front Groups investigated by Senators Grassley
 11 and Baucus, as evidenced by their May 8, 2012 letter arising out of their
 12 investigation of “extensive ties between companies that manufacture and market
 13 opioids and non-profit organizations” that “helped created a body of dubious
 14 information favoring opioids.”²³¹

15 484. The U.S. Pain Foundation (“USPF”) – The USPF was another Front
 16 Group with systematic connections and interpersonal relationships with the RICO
 17 Marketing Defendants. The USPF was one of the largest recipients of
 18 contributions from the RICO Marketing Defendants, collection nearly \$3 million
 19 in payments between 2012 and 2015 alone.²³² The USPF was also a critical
 20 component of the Opioid Marketing Enterprise’s lobbying efforts to reduce the
 21 limits on over-prescription. The U.S. Pain Foundation advertises its ties to the
 22 RICO Marketing Defendants, listing opioid manufacturers like Pfizer, Teva,
 23

24 230 June 8, 2012 Letter from Federation of State Medical Boards to U.S. Senators
 25 Max Baucus and Charles Grassley.

26 231 Letter from U.S. Senators Charles E. Grassley and Max Baucus to Catherine
 27 Underwood, Executive Director (May 8, 2012), American Pain Society,
<https://www.finance.senate.gov/imo/media/doc/05092012%20Baucus%20Grassley%20Opioid%20Investigation%20Letter%20to%20American%20Pain%20Society.pdf>.

28 232 *Fueling an Epidemic*, at p. 4.

1 Depomed, Endo, Purdue, McNeil (i.e. Janssen), and Mallinckrodt as “Platinum,”
 2 “Gold,” and “Basic” corporate members.²³³ Industry Front Groups like the
 3 American Academy of Pain Management, the American Academy of Pain
 4 Medicine, the American Pain Society, and PhRMA are also members of varying
 5 levels in the USPF.

6 485. American Geriatrics Society (“AGS”) – The AGS was another Front
 7 Group with systematic connections and interpersonal relationships with the RICO
 8 Defendants. The AGS was a large recipient of contributions from the RICO
 9 Marketing Defendants, including Endo, Purdue and Janssen. AGS contracted
 10 with the RICO Marketing Defendants to disseminate guidelines regarding the use
 11 of opioids for chronic pain in 2002 (*The Management of Persistent Pain in Older*
 12 *Persons*, hereinafter “2002 AGS Guidelines”) and 2009 (*Pharmacological*
 13 *Management of Persistent Pain in Older Persons*,²³⁴ hereinafter “2009 AGS
 14 Guidelines”). According to news reports, AGS has received at least \$344,000 in
 15 funding from opioid manufacturers since 2009.²³⁵ AGS’s complicity in the
 16 common purpose of the Opioid Marketing Enterprise is evidenced by the fact that
 17 AGS internal discussions in August 2009 reveal that it did not want to receive-up
 18 front funding from drug companies, which would suggest drug company
 19 influence, but would instead accept commercial support to disseminate pro-opioid
 20 publications.

21 486. Upon information and belief, representatives of the RICO Marketing
 22 Defendants, often at informal meetings at conferences, suggested activities,
 23
 24

24²³³ *Id.* at 12; Transparency, U.S. Pain Foundation,
 25 <https://uspainfoundation.org/transparency/> (last accessed on March 9, 2018).

26²³⁴ *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.
 27 Geriatrics Soc'y 1331, 1339, 1342 (2009), available at
<https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

28²³⁵ John Fauber & Ellen Gabler, *Narcotic Painkiller Use Booming Among Elderly*,
 Milwaukee J. Sentinel, May 30, 2012.

1 lobbying efforts and publications for AGS to pursue. AGS then submitted grant
2 proposals seeking to fund these activities and publications, knowing that drug
3 companies would support projects conceived as a result of these communications.

4 487. Plaintiffs are informed and believe that members of AGS Board of
5 Directors were doctors who were on the RICO Marketing Defendants' payrolls,
6 either as consultants or speakers at medical events. As described below, many of
7 the KOLs involved in the Opioid Marketing Enterprise also served in leadership
8 positions within the AGS.

9 488. There was regular communication between each of the RICO
10 Marketing Defendants, Front Groups and KOLs, in which information was shared,
11 misrepresentations were coordinated, and payments were exchanged. Typically,
12 the coordination, communication and payment occurred, and continues to occur,
13 through the use of the wires and mail in which the RICO Markets Defendants,
14 Front Groups, and KOLs share information necessary to overcome objections and
15 resistance to the use of opioids for chronic pain. The RICO Marketing
16 Defendants, Front Groups and KOLs functioned as a continuing unit for the
17 purpose of implementing the Opioid Marketing Enterprise's scheme and common
18 purpose, and each agreed to take actions to hide the scheme and continue its
19 existence.

20 489. At all relevant times, the Front Groups were aware of the RICO
21 Marketing Defendants' conduct, were knowing and willing participants in that
22 conduct, and reaped benefits from that conduct. Each Front Group also knew, but
23 did not disclose, that the other Front Groups were engaged in the same scheme, to
24 the detriment of consumers, prescribers, and The County. But for the Opioid
25 Marketing Enterprise's unlawful fraud, the Front Groups would have had
26 incentive to disclose the deceit by the RICO Marketing Defendants and the Opioid
27 Marketing Enterprise to their members and constituents. By failing to disclose
28

1 this information, Front Groups perpetuated the Opioid Marketing Enterprise's
2 scheme and common purpose, and reaped substantial benefits.

3 **3. The KOLs**

4 490. Similarly, each of the RICO Marketing Defendants financed,
5 supported, utilized and relied on the same KOLs by paying, financing, supporting,
6 managing, directing, or overseeing, and/or relying on their work. On Information
7 and belief, the RICO Marketing Defendants cultivated this small circle of doctors
8 solely because they favored the aggressive treatment of chronic pain with opioids.

9 491. The RICO Marketing Defendants and the Opioid Marketing
10 Enterprise relied on their KOLs to serve as part of their speakers bureaus and to
11 attend programs with speakers bureaus. The RICO Marketing Defendants graded
12 their KOLs on performance, post-program sales, and product usage. Furthermore,
13 the RICO Marketing Defendants expected their KOLs to stay "on message," and
14 obtained agreements from them, in writing, that "all slides must be presented in
15 their entirety and without alterations . . . and in sequence."

16 492. The RICO Marketing Defendants' KOLs have been at the center of
17 the Opioid Marketing Enterprise's marketing efforts, presenting the false
18 appearance of unbiased and reliable medical research supporting the broad use of
19 opioid therapy for chronic pain. As described in more detail below, the KOLs
20 have written, consulted, edited, and lent their names to books and articles, and
21 given speeches, and CMEs supporting chronic opioid therapy. They have served
22 on committees that developed treatment guidelines that strongly encourage the use
23 of opioids to treat chronic pain (even while acknowledging the lack of evidence in
24 support of that position) and on the boards of the pro-opioid Front Groups
25 identified above.

26 493. The RICO Marketing Defendants and KOLS all had systematic
27 connections and interpersonal relationships, as described below, through the
28 KOLs receipt of payments from the RICO Marketing Defendants and Front

1 Groups, the KOLs' authoring, publishing, speaking, and educating on behalf of
 2 the RICO Marketing Defendants, and their leadership roles and participation in
 3 the activities of the Front Groups, which were in turn financed by the RICO
 4 Marketing Defendants.

5 494. The systematic contacts and interpersonal relationships of the KOLs
 6 with the RICO Marketing Defendants and Front Groups are described below:

7 495. Dr. Russell Portenoy – Dr. Portenoy was one of the main KOLs that
 8 the RICO Marketing Defendants identified and promoted to further the common
 9 purpose of the Opioid Marketing Enterprise. Dr. Portenoy received research
 10 support, consulting fees, and honoraria from the RICO Defendants, and was a paid
 11 consultant to various RICO Marketing Defendants. Dr. Portenoy was
 12 instrumental in opening the door for the regular use of opioids to treat chronic
 13 pain. Dr. Portenoy is credited as one of the authors on a primary pillar of the
 14 RICO Marketing Defendants' misrepresentation regarding the risks and benefits
 15 of opioid use.²³⁶ Dr. Portenoy had financial relationships with at least a dozen
 16 pharmaceutical companies, most of which produced prescription opioids.²³⁷

17
 18
 19 ²³⁶ In 1986, the medical journal Pain, which would eventually become the official
 20 journal of the American Pain Society ("APS"), published an article by Portenoy
 21 and Foley summarizing the results of a "study" of 38 chronic non-cancer pain
 22 patients who had been treated with opioid painkillers. Portenoy and Foley
 23 concluded that, for non-cancer pain, opioids "can be safely and effectively
 24 prescribed to selected patients with relatively little risk of producing the
 25 maladaptive behaviors which define opioid abuse." However, their study was
 26 neither scientific nor did it meet the rigorous standards commonly used to evaluate
 27 the validity and strength of such studies in the medical community. For instance,
 28 there was no placebo control group, and the results were retroactive (asking
 patients to describe prior experiences with opioid treatment rather than less biased,
 in-the-moment reports). The authors themselves advised caution, stating that the
 drugs should be used as an "alternative therapy" and recognizing that longer term
 studies of patients on opioids would have to be performed. None were. See Russell
 K. Portenoy & Kathleen M. Foley, *Chronic use of opioid analgesics in non-*
malignant pain: report of 38 cases, 25(2) Pain 171-86 (May 1986).

29
 30 ²³⁷ Anna Lembke, Drug Dealer, MD: How Doctors Were Duped, Patients Got
 31 Hooked, and Why It's So Hard to Stop, (Johns Hopkins University Press 2016), at
 32 59 (citing Barry Meier, Pain Killer: A "Wonder" Drug's Trail of Addiction and
 Death (St. Martin's Press, 1st Ed 2003).

1 496. In exchange for the payments he received from the RICO Marketing
 2 Defendants, Dr. Portenoy is credited as one of the authors on a primary pillar of
 3 the RICO Marketing Defendants' misrepresentation regarding the risks and
 4 benefits of opioids.²³⁸ Dr. Portenoy, published, spoke, consulted, appeared in
 5 advertisements and on television broadcasts, and traveled the country to travel the
 6 country to promote more liberal prescribing for many types of pain and conduct
 7 continuing medical education ("CME") seminars sponsored by the RICO
 8 Marketing Defendants and Front Groups.

9 497. Dr. Portenoy was also a critical component of the RICO Marketing
 10 Defendants' control over their Front Groups, and the Front Groups support of the
 11 Opioid Marketing Enterprise's common purpose. Specifically, Dr. Portenoy sat as
 12 a Director on the board of the APF. He was also the President of the APS.

13 498. In a 2011 interview released by Physicians for Responsible Opioid
 14 Prescribing, Dr. Portenoy admitted that his earlier work relied on evidence that
 15 was not "real" and left real evidence behind, all in furtherance of the Opioid
 16 Marketing Enterprise's common purpose:

17 I gave so many lectures to primary care audiences in which the Porter
 18 and Jick article was just one piece of data that I would then cite, and I
 19 would cite six, seven, maybe ten different avenues of thought or
 20 avenues of evidence, none of which represented real evidence, and yet
 what I was trying to do was to create a narrative so that the primary

21 ²³⁸ In 1986, the medical journal Pain, which would eventually become the official
 22 journal of the American Pain Society ("APS"), published an article by Portenoy
 23 and Foley summarizing the results of a "study" of 38 chronic non-cancer pain
 24 patients who had been treated with opioid painkillers. Portenoy and Foley
 25 concluded that, for non-cancer pain, opioids "can be safely and effectively
 26 prescribed to selected patients with relatively little risk of producing the
 27 maladaptive behaviors which define opioid abuse." However, their study was
 28 neither scientific nor did it meet the rigorous standards commonly used to evaluate
 the validity and strength of such studies in the medical community. For instance,
 there was no placebo control group, and the results were retroactive (asking
 patients to describe prior experiences with opioid treatment rather than less biased,
 in-the-moment reports). The authors themselves advised caution, stating that the
 drugs should be used as an "alternative therapy" and recognizing that longer term
 studies of patients on opioids would have to be performed. None were. See Russell
 K. Portenoy & Kathleen M. Foley, *Chronic use of opioid analgesics in non-*
malignant pain: report of 38 cases, 25(2) Pain 171-86 (May 1986).

1 care audience would look at this information in [total] and feel more
 2 comfortable about opioids in a way they hadn't before. In essence this
 3 was education to destigmatize [opioids], and because the primary goal
 4 was to destigmatize, we often left evidence behind.²³⁹

5 499. Dr. Lynn Webster – Dr. Webster was a critical component of the
 6 Opioid Marketing Enterprise, including advocating the RICO Marketing
 7 Defendants' fraudulent messages regarding prescription opioids and had
 8 systematic contacts and personal relationships with the RICO Marketing
 9 Defendants and the Front Groups.

10 500. Dr. Webster was the co-founder and Chief Medical Director of an
 11 otherwise unknown pain clinic in Salt Lake City, Utah (Lifetree Clinical
 12 Research), who went on to become one of the RICO Marketing Defendants' main
 13 KOLs. Dr. Webster was the President of American Academy of Pain Medicine
 14 ("AAPM") in 2013. He is a Senior Editor of Pain Medicine, the same journal that
 15 published Endo special advertising supplements touting Opana ER. Dr. Webster
 16 was the author of numerous CMEs sponsored by Cephalon, Endo, and Purdue. At
 17 the same time, Dr. Webster was receiving significant funding from the RICO
 18 Marketing Defendants (including nearly \$2 million from Cephalon alone).

19 501. During a portion of his time as a KOL, Dr. Webster was under
 20 investigation for overprescribing by the U.S. Department of Justice's Drug
 21 Enforcement Agency, which raided his clinic in 2010. Although the investigation
 22 was closed without charges in 2014, more than twenty (20) of Dr. Webster's
 23 former patients at the Lifetree Clinic have died of opioid overdoses.

24 502. Dr. Webster created and promoted the Opioid Risk Tool, a five
 25 question, one-minute screening tool relying on patient self-reports that purportedly
 26 allows doctors to manage the risk that their patients will become addicted to or
 27 abuse opioids. The claimed ability to pre-sort patients likely to become addicted is

28 ²³⁹ Andrew Kolodny, *Opioids for Chronic Pain: Addiction is NOT Rare*, YouTube
 29 (Oct. 30, 2011),
 30 <https://www.youtube.com/watch?v=DgyuBWN9D4w&feature=youtu.be>.

1 an important tool in giving doctors confidence to prescribe opioids long-term, and,
 2 for this reason, references to screening appear in various industry-supported
 3 guidelines. Versions of Dr. Webster's Opioid Risk Tool appear on, or are linked
 4 to, websites run by Endo, Janssen, and Purdue.

5 503. Dr. Webster is also credited as one of the leading proponents of
 6 "pseudoaddiction" that the RICO Marketing Defendants, Front Groups and KOLs
 7 disseminated as part of the common purpose of the Opioid Marketing Enterprise.

8 504. Plaintiff The County is informed and believes that in exchange for
 9 the payments he received from the RICO Marketing Defendants, Dr. Webster
 10 published, spoke, consulted, appeared in advertisements and on television
 11 broadcasts, and traveled the country to promote more liberal prescribing of
 12 opioids for many types of pain and conduct CME seminars sponsored by the
 13 RICO Marketing Defendants and Front Groups.

14 505. Like Dr. Portenoy, Dr. Webster later reversed his opinion and
 15 disavowed his previous work on and opinions regarding pseudoaddiction.
 16 Specifically, Dr. Webster acknowledged that "[pseudoaddiction] obviously
 17 became too much of an excuse to give patients more medication."²⁴⁰

18 506. Dr. Perry Fine – Dr. Webster was a critical component of the Opioid
 19 Marketing Enterprise, including advocating the RICO Marketing Defendants'
 20 fraudulent messages regarding prescription opioids and had systematic contacts
 21 and personal relationships with the RICO Marketing Defendants and the Front
 22 Groups.

23 507. Dr. Fine was originally a doctor practicing in Utah, who received
 24 support from the RICO Marketing Defendants, including Janssen, Cephalon,
 25 Endo, and Purdue. Dr. Fine's ties to the RICO Marketing Defendants have been
 26

27 240 John Fauber, *Painkiller Boom Fueled by Networking*, Milwaukee Wisc. J.
 28 Sentinel, Feb. 18, 2012,
<http://archive.jsonline.com/watchdog/watchdogreports/painkiller-boom-fueled-by-networking-dp3p2rn-139609053.html>.

1 well documented.²⁴¹ He has authored articles and testified in court cases and
 2 before state and federal committees, and he served as president of the AAPM, and
 3 argued against legislation restricting high-dose opioid prescription for non-cancer
 4 patients. Multiple videos featured Fine delivering educational talks about
 5 prescription opioids. He even testified in a trial that the 1,500 pills a month
 6 prescribed to celebrity Anna Nicole Smith for pain did not make her an addict
 7 before her death.²⁴² He has also acknowledged having failed to disclose numerous
 8 conflicts of interest.

9 508. Dr. Fine was also a critical component of the RICO Marketing
 10 Defendants' control over their Front Groups, and the Front Groups support of the
 11 Opioid Marketing Enterprise's common purpose. Specifically, Dr. Fine served on
 12 the Board of Directors of APF and served as the President of the AAPM in 2011.

13 509. Plaintiff The County is informed and believes that in exchange for
 14 the payments he received from the RICO Marketing Defendants, Dr. Fine
 15 published, spoke, consulted, appeared in advertisements and on television
 16 broadcasts, and traveled the country to promote more liberal prescribing of
 17 opioids for many types of pain and conduct CME seminars sponsored by the
 18 RICO Marketing Defendants and Front Groups.

19 510. Dr. Scott M. Fishman – Dr. Fishman was a critical component of the
 20 Opioid Marketing Enterprise, including advocating the RICO Marketing
 21 Defendants' fraudulent messages regarding prescription opioids and had
 22
 23
 24

25 ²⁴¹ Tracy Weber & Charles Ornstein, *Two Leaders in Pain Treatment Have Long*
 26 *Ties to Drug Industry*, ProPublica (Dec. 23, 2011, 2:14 PM),
<https://www.propublica.org/article/two-leaders-in-pain-treatment-have-long-ties-to-drug-industry>

27 ²⁴² Linda Deutsch, *Doctor: 1,500 pills don't prove Smith was addicted*, Seattle
 28 Times (Sept. 22, 2010, 5:16 PM),
<http://www.seattletimes.com/entertainment/doctor-1500-pills-dont-prove-smithwas-addicted/>.

1 systematic contacts and personal relationships with the RICO Marketing
 2 Defendants and the Front Groups.

3 511. Although Dr. Fishman did not receive direct financial payments from
 4 the RICO Marketing Defendants, his ties to the opioid drug industry are legion.²⁴³

5 512. As Dr. Fishman's personal biography indicates, he is critical
 6 component of the RICO Marketing Defendants' control over their Front Groups,
 7 and the Front Groups support of the Opioid Marketing Enterprise's common
 8 purpose. Specifically, Dr. Fishman is an "internationally recognized expert on
 9 pain and pain management" who has served in "numerous leadership roles with
 10 the goal to alleviate pain."²⁴⁴ Dr. Fishman's roles in the pain industry include
 11 "past president of the American Academy of Pain Medicine [AAPM], past
 12 chairman of the board of directors of the American Pain Foundation [APF], and
 13 past board member of the American Pain Society [APS]."²⁴⁵ Dr. Fishman is also
 14 "the immediate past chair and current member of the Pain Care Coalition of the
 15 American Society of Anesthesiologists, American Pain Society, and Academy of
 16 Pain Medicine."²⁴⁶ Dr. Fishman's leadership positions within the central core of
 17 the RICO Marketing Defendants' Front Groups was a direct result of his
 18 participation in the Opioid Marketing Enterprise and agreement to cooperate with
 19 the RICO Marketing Defendants' pattern of racketeering activity.

20 513. Plaintiff The County is informed and believes that in exchange for
 21 the payments he received from the RICO Marketing Defendants, Dr. Fishman
 22 published, spoke, consulted, appeared in advertisements and on television
 23
 24

25 ²⁴³ Scott M. Fishman, M.D., Professor, U.C. Davis Health, Center for Advancing
 26 Pain Relief,
https://www.ucdmc.ucdavis.edu/advancingpainrelief/our_team/Scott_Fishman.htm
 1 (accessed on February 28, 2018).

27 ²⁴⁴ *Id.*

28 ²⁴⁵ *Id.*

29 ²⁴⁶ *Id.*

1 broadcasts, and traveled the country to promote more liberal prescribing of
2 opioids for many types of pain and conduct CME seminars sponsored by the
3 RICO Marketing Defendants and Front Groups.

4 514. There was regular communication between each of the RICO
5 Marketing Defendants, Front Groups and KOLs, in which information was shared,
6 misrepresentations are coordinated, and payments were exchanged. Typically, the
7 coordination, communication and payment occurred, and continues to occur,
8 through the use of the wires and mail in which the RICO Marketing Defendants,
9 Front Groups, and KOLs share information regarding overcoming objections and
10 resistance to the use of opioids for chronic pain. The RICO Marketing
11 Defendants, Front Groups and KOLs functioned as a continuing unit for the
12 purpose of implementing the Opioid Marketing Enterprise's scheme and common
13 purpose, and each agreed to take actions to hide the scheme and continue its
14 existence.

15 515. At all relevant times, the KOLs were aware of the RICO Marketing
16 Defendants' conduct, were knowing and willing participants in that conduct, and
17 reaped benefits from that conduct. The RICO Marketing Defendants selected
18 KOLs solely because they favored the aggressive treatment of chronic pain with
19 opioids. The RICO Marketing Defendants' support helped the KOLs become
20 respected industry experts. And, as they rose to prominence, the KOLs falsely
21 touted the benefits of using opioids to treat chronic pain, repaying the RICO
22 Marketing Defendants by advancing their marketing goals. The KOLs also knew,
23 but did not disclose, that the other KOLS and Front Groups were engaged in the
24 same scheme, to the detriment of consumers, prescribers, and The County. But
25 for the Opioid Marketing Enterprise's unlawful conduct, the KOLs would have
26 had incentive to disclose the deceit by the RICO Marketing Defendants and the
27 Opioid Marketing Enterprise, and to protect their patients and the patients of other
28 physicians. By failing to disclose this information, KOLs furthered the Opioid

1 Marketing Enterprise's scheme and common purpose, and reaped substantial
2 benefits.

3 516. As public scrutiny and media coverage focused on how opioids
4 ravaged communities in California and throughout the United States, the Front
5 Groups and KOLS did not challenge the RICO Marketing Defendants'
6 misrepresentations, seek to correct their previous misrepresentations, terminate
7 their role in the Opioid Marketing Enterprise, nor disclose publicly that the risks
8 of using opioids for chronic pain outweighed their benefits and were not supported
9 by medically acceptable evidence.

10 517. The RICO Marketing Defendants, Front Groups and KOLs engaged
11 in certain discrete categories of activities in furtherance of the common purpose of
12 the Opioid Marketing Enterprise. As reported in *Fueling an Epidemic*, the Opioid
13 Marketing Enterprise's conduct in furtherance of the common purpose of the
14 Opioid Marketing Enterprise involved: (1) misrepresentations regarding the risk
15 of addiction and safe use of prescription opioids for long-term chronic pain; (2)
16 lobbying to defeat measures to restrict over-prescription; (3) efforts to criticize or
17 undermine CDC guidelines; and (4) efforts to limit prescriber accountability. The
18 misrepresentations made in these publications are described in the following
19 section.

20 518. Efforts to Minimize the Risk of Addiction and Promote Opioid Use
21 As Safe for Long-Term Treatment of Chronic Pain – Members of the Opioid
22 Marketing Enterprise furthered the common purpose of the enterprise by
23 publishing and disseminating statements that minimized the risk of addiction and
24 misrepresented the safety of using prescription opioids for long-term treatment of
25 chronic, non-acute, and non-cancer pain. The categories of misrepresentations

26

27

28

1 made by the Opioid Marketing Enterprise and the RICO Defendants included the
 2 following:²⁴⁷

- 3 • The Use of Opioids for the Treatment of Chronic Pain: A Consensus
 4 Statement From the American Academy of Pain Medicine and the
 5 American Pain Society, 13 Clinical J. Pain 6 (1997). The “landmark
 6 consensus” was published by the AAPM and APS. Dr. Portenoy was the
 7 sole consultant. A member of Purdue’s speaker bureau authored the
 8 consensus.
- 9 • *Model Guidelines for the Use of Controlled Substances for the Treatment of*
 10 *Pain* (1998, 2004, 2007).²⁴⁸ These guidelines, originally published by the
 11 FSMB in collaboration with RICO Defendants, advocated that opioids were
 12 “essential” and that “misunderstanding of addiction” contributed to
 13 undertreated pain.
- 14 • Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on
 15 Health, Education, Labor and Pensions, Testimony by John D. Giglio,
 16 M.A., J.D., Executive Direction of the APF (2002).²⁴⁹
- 17 • *The Management of Persistent Pain in Older Persons* (2002). These
 18 guidelines were published by AGS with substantial funding from Endo,
 19 Purdue and Janssen.
- 20 • *Overview of Management Options* (2003, 2007, 2010, and 2013).²⁵⁰ This
 21 CME was edited by Dr. Portenoy, sponsored by Purdue, and published by

23 ²⁴⁷ As noted below, the earliest misrepresentations disseminated by the RICO
 24 Defendants and the Opioid Marketing Enterprise began in 1997 and has continued
 25 unabated since that time. Therefore, this list is alleged as fully and completely as
 26 possible.

27 ²⁴⁸ *Model Policy for the Use of Controlled Substances for the Treatment of Pain*,
 28 Federation of State Medical Boards of the United States, May 2004,
 https://www.ihs.gov/painmanagement/includes/themes/newihstheme/display_objects/documents/modelpolicytreatmentpain.pdf (last accessed on March 9, 2018).

29 ²⁴⁹ Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health,
 30 Education, Labor and Pensions, Testimony by John D. Giglio, M.A., J.D.,
 31 Executive Direction of the APF (2002.)

1 the American Medical Association. It taught that opioids, unlike non-
 2 prescription pain medication are safe at high doses.

- 3 • *Understanding Your Pain: Taking Oral Opioid Analgesics* (2004).²⁵¹ This
 4 article, published by Endo Pharmaceuticals advocated that withdrawal and
 5 needing to take higher dosages are not signs of addiction.
- 6 • Interview by Paula Moyer with Scott M. Fishman, M.D. (2005). Dr.
 7 Fishman advocated that “the risks of addiction are . . . small and can be
 8 managed.”²⁵²
- 9 • Open-label study of fentanyl effervescent buccal tablets in patients with
 10 chronic pain and breakthrough pain: interim safety and tolerability results
 11 (2006).²⁵³ Dr. Webster gave this CME, sponsored by Cephalon, that
 12 misrepresented that opioids were safe for the treatment of non-cancer pain.
- 13 • *Treatment Options: A Guide for People Living With Pain* (2007). This
 14 document was published by the APF and sponsored by Cephalon and
 15 Purdue.²⁵⁴

16
 17
 18 ²⁵⁰ Portenoy, et al., *Overview of Management Options*, <https://cme.ama-assn.org/activity/1296783/detail.aspx>. On information and belief, this CME was
 19 published by the American Medical Association in 2003, 2007, 2010, and 2013.

20
 21 ²⁵¹ Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004),
<https://www.yumpu.com/en/document/view/35479278/understanding-your-pain-taking-oral-opioid-analgesics> (last accessed March 8, 2018).

22
 23 ²⁵² Interview by Paula Moyer with Scott M. Fishman, M.D., Professor of Anesthesiology and Pain Medicine, Chief of the Division of Pain Medicine, Univ. of Cal., Davis (2005), available at <http://www.medscape.org/viewarticle/500829>.

24
 25 ²⁵³ Hale ME, Webster LR, Peppin JF, Messina J. Open-label study of fentanyl effervescent buccal tablets in patients with chronic pain and breakthrough pain: interim safety and tolerability results. Program and abstracts of the annual meeting of the American Academy of Pain Medicine; February 22-25, 2006; San Diego, California. Abstract 120. Published with permission of Lynn R. Webster, MD, https://www.medscape.org/viewarticle/524538_2 (accessed on March 6, 2018).

26
 27 ²⁵⁴ Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007) [hereinafter APF, *Treatment Options*],
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf> (last accessed on March 8, 2018).

- 1 • *Responsible Opioid Prescribing: A Physician's Guide* (2007).²⁵⁵ This
2 book, authored by Dr. Fishman was financed by the FSMB with funding
3 from Cephalon, Endo and Purdue.
- 4 • *Avoiding Opioid Abuse While Managing Pain* (2007).²⁵⁶ This book, co-
5 authored by Dr. Webster, misrepresented that for prescribers facing signs of
6 aberrant behavior, increasing the dose in “most cases . . . should be a
7 clinician’s first response.”
- 8 • *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version
9 1.0-SF* (2008).²⁵⁷ This screening tool was published by the National
10 Institutes of Health with support from Endo through an educational grant,
11 and advocated that most patients are able to successfully remain on long-
12 term opioid therapy without significant problems.
- 13 • *Case Challenges in Pain Management: Opioid Therapy for Chronic Pain*
14 (2007).²⁵⁸ This article, sponsored by Endo, misrepresented that opioids are
15 a highly effective class of analgesic drugs.
- 16 • *Opioid-Based Management of Persistent and Breakthrough Pain* (2008).²⁵⁹
17 This document was written by Dr. Fine and sponsored by an educational
18
19

20 ²⁵⁵ Scott M. Fishman, *Responsible Opioid Prescribing: A Physician's Guide*, 8-9
21 (Waterford Life Sciences 2007).

22 ²⁵⁶ Lynn Webster & Beth Dove, *Avoiding Opioid Abuse While Managing Pain*
23 (2007).

24 ²⁵⁷ *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0-SF*, PainEdu.org, 2008, <https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf> (last accessed on March 8, 2018).

25 ²⁵⁸ Charles E. Argoff, *Case Challenges in Pain Management: Opioid Therapy for Chronic Pain*, Pain Med. News,
26 https://www.painmedicinewebs.com/download/BtoB_Opana_WM.pdf (last visited on March 8, 2018).

27 ²⁵⁹ Perry G Fine, MD, et al. *Opioid-Based Management of Persistent and Breakthrough Pain*, Pain Medicine News,
28 <https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain> (accessed on February 27, 2018).

1 grant from Cephalon. Dr. Fine advocated for the prescription of rapid onset
 2 opioids “in patients with non-cancer pain.”

- 3 • *Optimizing Opioid Treatment for Breakthrough Pain* (2008).²⁶⁰ Dr.
 4 Webster presented an online seminar (webinar) sponsored by Cephalon, that
 5 misrepresented that non-opioid analgesics and combination opioids
 6 containing non-opioids are less effective because of dose limitations.
- 7 • *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-*
 8 *Cancer Pain* (2009).²⁶¹ These guidelines were published by AAPM and
 9 APS. Fourteen of the twenty-one panel members, including Dr. Portenoy
 10 and Dr. Fine, received support from the RICO Defendants.
- 11 • *Pharmacological Management of Persistent Pain in Older Persons*
 12 (2009).²⁶² These guidelines were published by AGS, with substantial
 13 funding from Endo, Purdue, and Janssen, updated the 2002 guidelines and
 14 misrepresented that the risks of addiction are exceedingly low.
- 15 • Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit
 16 Wounds: A Survival Guide to Pain Management for Returning Veterans
 17 and Their Families,²⁶³ American Pain Foundation, 2009. This article was
 18 published in 2009 and sponsored by Purdue.

20
 21 ²⁶⁰ Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, Medscape,
 22 http://www.medscape.org/viewarticle/563417_6 (last visited Dec. 11, 2017).

22 ²⁶¹ Roger Chou et al., *Clinical Guidelines for the Use of Chronic Opioid Therapy in*
 23 *Chronic Non-Cancer Pain*, 10 J. Pain 113 (2009).

23 ²⁶² *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.
 24 Geriatrics Soc'y 1331, 1339, 1342 (2009), available at
<https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

25 ²⁶³ Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit
 26 Wounds: A Survival Guide to Pain Management for Returning Veterans and Their
 27 Families, Coalition for Iraq + Afghanistan Veterans,
<http://web.archive.org/web/20100308224011/http://coalitionforveterans.org:80/2009/10/iraq-war-veteran-amputee-pain-advocate-and-new-author-releases-exit-wounds-a-survival-guide-to-pain-management-for-returning-veterans-and-their-families> (last visited March 1, 2018)

- 1 • *Finding Relief: Pain Management for Older Adults*, (2009).²⁶⁴ This article
2 was a collaboration between the American Geriatrics Society, AAPM and
3 Janssen.
- 4 • Good Morning America (2010). Dr. Portenoy appeared on Good Morning
5 America and stated that “Addiction, when treating pain, is distinctly
6 uncommon.”²⁶⁵
- 7 • *A Policymaker’s Guide to Understanding Pain & Its Management, American Pain Foundation* (2011).²⁶⁶ APF published this document, that
8 was sponsored by Purdue, which argued that the notion of strong pain
9 leading to addiction is a common misconception.
- 10 • *Managing Patient’s Opioid Use: Balancing the Need and the Risk* (2011).²⁶⁷ Dr. Webster presented a webinar, sponsored by Purdue, that
11 misrepresented the ability to use risk screen tools, urine samples and patient
12 agreements to prevent overuse and overdose death.
- 13 • *Safe and Effective Opioid Rotation* (2012).²⁶⁸ This CME, delivered by Dr.
14 Fine, that is also available online, advocated for the safe and non-addictive
15 use of opioids to treat cancer and non-cancer patients over a person’s
16 “lifetime.”

19
20
21 ²⁶⁴ Finding Relief, Pain Management for Older Adults, (2009).

22 ²⁶⁵ Good Morning America (ABC television broadcast Aug. 30, 2010).

23 ²⁶⁶ *A Policymaker’s Guide to Understanding Pain & Its Management, American Pain Foundation* (2011) at

24 5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

25 ²⁶⁷ See, *Managing Patient’s Opioid Use: Balancing the Need and the Risk, Emerging Solutions in Pain* http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209 (last visited Aug. 22, 2017).

26 ²⁶⁸ Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),
27 https://www.youtube.com/watch?v=_G3II9yqgXI.

1 • *Pain: Opioid Facts* (2012).²⁶⁹ This document was published online on
 2 Endo's website painknowledge.org and advocated for the use of opioids and
 3 downplayed the risk of addiction, even for people with a history of
 4 addiction and opioid use, and supported the concept of pseudoaddiction.

5 519. Efforts to Criticize or Undermine CDC Guidelines – Members of the
 6 Opioid Marketing Enterprise criticized or undermined the CDC Guidelines which
 7 represented “an important step – and perhaps the first major step from the federal
 8 government – toward limiting opioid prescriptions for chronic pain.” The
 9 following are examples of the actions taken by Opioid Marketing Enterprise
 10 members to prevent restriction on over-prescription:

11 • Several Front Groups, including the U.S. Pain Foundation, and the AAPM
 12 criticized the draft guidelines in 2015, arguing that the “CDC slides
 13 presented on Wednesday were not transparent relative to process and failed
 14 to disclose the names, affiliation, and conflicts of interest of the individuals
 15 who participated in the construction of these guidelines.”²⁷⁰

16 • The AAPM criticized the prescribing guidelines in 2016, through its
 17 immediate past president, stating “that the CDC guideline makes
 18 disproportionately strong recommendations based upon a narrowly selected
 19 portion of the available clinical evidence.”²⁷¹

20
 21
 22

 23 ²⁶⁹ *Pain: Opioid Facts*,
 24 http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380_b385%20%20pf%20opioid.pdf (last visited March 6, 2018).

25 ²⁷⁰ Pat Anson, *Chronic Pain Group Blasts CDC for Opioid Guidelines*, Pain News
 26 Networks, <https://www.painnewsnetwork.org/stories/2015/9/22/chronic-pain-groups-blast-cdc-for-opioid-guidelines> (last accessed on March 8, 2018).

27 ²⁷¹ Practical Pain Management, Responses and Criticisms Over New CDC Opioid
 28 Prescribing Guidelines
 29 (<https://www.practicalpainmanagement.com/resources/news-and-research/responses-criticisms-over-new-cdc-opioid-prescribing-guidelines>)
 30 (accessed Sept. 28, 2017).

1 520. In each of the actions performed by members of the Opioid
2 Marketing Enterprise, described above, the members of the Opioid Marketing
3 Enterprise made branded and unbranded marketing claims about prescription
4 opioids that misrepresented prescription opioids as non-addictive and safe for use
5 as identified in following section.

6 **4. Members of the Opioid Marketing Enterprise**
7 **Furthered the Common Purpose by Making**
8 **Misrepresentations.**

9 521. The RICO Marketing Defendants, Front Groups and KOLs
10 participated in the conduct of the Opioid Marketing Enterprise and shared in the
11 common purpose of marketing opioids for chronic pain through a pattern of
12 racketeering activity (including multiple instances of mail and wire fraud) by
13 knowingly making material misrepresentations or omissions to California
14 prescribers, consumers, the general public, regulators and The County. All of the
15 misrepresentations made by members of the Opioid Marketing Enterprise
16 furthered the common purpose of the Enterprise.

17 522. Members of the Opioid Marketing Enterprise, including the RICO
18 Marketing Defendants, Front Groups and KOLs made multiple unbranded
19 marketing misrepresentations about the benefits and risks of opioid use, in
20 furtherance of the Opioid Marketing Enterprise's common purpose, as follows:

21 523. Members of the Opioid Marketing Enterprise minimized the risks of
22 addiction and/or construed opioids as non-addictive:

23 • AAMP and APS endorsed the use of opioids to treat chronic pain and
24 claimed that the risk of a patients' addiction to opioids was low.²⁷²

27

²⁷² The Use of Opioids for the Treatment of Chronic Pain: A Consensus Statement
28 From the American Academy of Pain Medicine and the American Pain Society, 13
Clinical J. Pain 6 (1997).

- “[O]pioids are safe and effective, and only in rare cases lead to addiction.”²⁷³
- “[T]he risks of addiction are . . . small and can be managed.”²⁷⁴

Medscape: Controversy surrounds both the undertreatment and overtreatment of pain. Overtreatment of pain obviously involves the fear of causing or perpetuating opioid drug dependency. What recommendations can you give to primary care physicians who are reluctant to prescribe opioids, either as adjuncts or primary agents for pain control, because of these fears?

Dr. Fishman: It used to be that when you had a patient with pain and you were worried about giving him or her a drug that may be abusable or may cause addiction, the safest thing to do was nothing, as though doing nothing would have no risks in and of itself. We know that the risks of addiction are there, but they are small and can be managed. The AAPM is going to be at the forefront, educating

- Represented that calling opioids “‘narcotics’ reinforces myths and misunderstandings as it places emphasis on their potential abuse rather than on the importance of their use as pain medicines.”²⁷⁵
- “Addiction, when treating pain, is distinctly uncommon. If a person does not have a history, a personal history, of substance abuse, and does not have a history in the family of substance abuse, and does not have a very major psychiatric disorder, most doctors can feel very assured that that person is not going to become addicted.”²⁷⁶

OPIOID ANALGESICS (NARCOTICS)

Opioid analgesics are another important class of medications that are very effective pain relievers. As mentioned before, they may also be called "narcotics." Unfortunately, this term is used by law enforcement to refer to drugs that are abused. Cocaine and heroin are called narcotics even though they are very different kinds of drugs. Calling opioid analgesics "narcotics" reinforces myths and misunderstandings as it places emphasis on their potential abuse rather than on the importance of their use as pain medicines. In the pain treatment world, the word opioid is used when speaking about this class of medications.

²⁷³ *Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health, Education, Labor and Pensions*, 107th Cong. 2 (Feb. 12, 2002) (testimony of John D. Giglio, M.A., J.D., Executive Director, American Pain Foundation), <https://www.help.senate.gov/imo/media/doc/Giglio.pdf>.

²⁷⁴ Interview by Paula Moyer with Scott M. Fishman, M.D., Professor of Anesthesiology and Pain Medicine, Chief of the Division of Pain Medicine, Univ. of Cal., Davis (2005), available at <http://www.medscape.org/viewarticle/500829>.

²⁷⁵ APF, *Treatment Options*, <https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf> (last accessed on March 8, 2018).

²⁷⁶ Good Morning America (ABC television broadcast Aug. 30, 2010).

- 1 • The risk of addiction is manageable for patients regardless of past abuse
2 histories.²⁷⁷
- 3 • “[T]he likelihood that the treatment of pain using an opioid drug which is
4 prescribed by a doctor will lead to addiction is extremely low.”²⁷⁸
- 5 • Patients might experience withdrawal symptoms associated with physical
6 dependence as they decrease their dose, “[b]ut unlike actual addicts, such
7 individuals, if they resume their opioid use, will only take enough
8 medication to alleviate their pain.”²⁷⁹
- 9 • The notion that “strong pain medication leads to addiction” is a “common
10 misconception.”²⁸⁰

SOME COMMON MISCONCEPTIONS ABOUT PAIN

13 **Use of strong pain medication leads to addiction.** Many people living with
14 pain, and even some health care practitioners, falsely believe that opioid pain
15 medicines are universally addictive. As with any medication, there are risks, but
16 these risks can be managed when these medicines are properly prescribed and
 taken as directed. For more information about safety issues related to opioids
 and other pain therapies, visit www.painsafe.org.

20 _____
21 ²⁷⁷ Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in
Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

22 ²⁷⁸ Thomas Catan and Evan Perez, *A Pain-Drug Champion Has Second Thoughts*,
The Wall Street Journal (Dec. 17, 2012),
<https://www.wsj.com/articles/SB10001424127887324478304578173342657044604>.

23 ²⁷⁹ Brief Amici Curiae of American Pain Foundation, National Foundation for the
Treatment of Pain, and The Ohio Pain Initiative, in Support of
Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA
2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),
<https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

24 ²⁸⁰ A Policymaker’s Guide to Understanding Pain & Its Management, American
Pain Foundation (2011) at 5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

- “Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don’t need it for pain, maybe just to escape your problems.”²⁸¹

How can I be sure I'm not addicted?

- ◆ Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don't need it for pain, maybe just to escape from your problems.
- ◆ Ask yourself: Would I want to take this medicine if my pain went away? If you answer no, you are taking opioids for the right reasons—to relieve your pain and improve your function. You are not addicted.

- Even for patients assessed to have a risk of abuse, “it does not mean that opioid use will become problematic or that opioids are contraindicated.”²⁸²

WILL I BECOME ADDICTED TO OPIOIDS?

This is a key issue for both you and your doctor to discuss. In general, people who have no history of drug abuse, including tobacco, and use their opioid medication as directed will probably not become addicted. However, patients who misuse or abuse opioids can become addicted to them, so openly discussing your concerns with your doctor is important. People who are addicted to opioids crave the "unusually happy" effect the drug has on them (a "buzz" or "high") and will continue to use the drug even though it harms them.



²⁸¹ Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004), <https://www.yumpu.com/en/document/view/35479278/understanding-your-pain-taking-oral-opioid-analgesics> (last accessed March 8, 2018).

²⁸² Scott M. Fishman, *Responsible Opioid Prescribing: A Physician's Guide*, 8-9 (Waterford Life Sciences 2007).

- 1 • [P]eople who have no history of drug abuse, including tobacco, and use
2 their opioid medication as directed will probably not become addicted.”²⁸³
- 3 • “A history of addiction would not rule out the use of opioid pain
4 relievers.”²⁸⁴



A history of addiction would not rule out the use of opioid pain relievers.

- 9 • APF published exit wounds, wherein it represented that “[l]ong experience
10 with opioids shows that people who are not predisposed to addiction are
11 very unlikely to become addicted to opioid pain medications.”²⁸⁵

Iraq War Veteran Amputee, Pain Advocate and New Author Releases Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families



“It’s now four years since I lay in the dirt, near death, on the side of the road in Fallujah. I’m grateful for all the things I have, and proud of all I’ve accomplished. In the end though, I don’t measure how far I’ve come by goals achieved, or academic degrees earned, or running trophies won. For me, what counts is that pain no longer rules my life.” – Derek McGinnis

The American Pain Foundation (APF) announces the release of Iraq War Veteran and Pain Advocate Derek McGinnis’ first book, *Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families*. Written in collaboration with nationally renowned pain experts, the release date of September 21 for *Exit Wounds* coincided with September’s designation as Pain Awareness Month.

- 20 • Patients rarely become addicted to prescribed opioids.²⁸⁶

22

²⁸³ *Pain: Opioid Facts*,
23 <http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patiente>
24 nted/pdf/Patient%20Education%20b380_b385%20%20pf%20opioid.pdf (last
visited March 6, 2018).

25 ²⁸⁴ *Id.*

26 ²⁸⁵ Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit
27 Wounds: A Survival Guide to Pain Management for Returning Veterans and Their
28 Families, Coalition for Iraq + Afghanistan Veterans,
 <http://web.archive.org/web/20100308224011/http://coalitionforveterans.org:80/2009/10/iraq-war-veteran-amputee-pain-advocate-and-new-author-releases-exit-wounds-a-survival-guide-to-pain-management-for-returning-veterans-and-their-families> (last visited March 1, 2018).

- 1 • Concern about patients becoming addicted reflects widespread failure to
 2 appreciate the distinction between “(1) *tolerance* – the body’s tendency to
 3 become accustomed to a substance so that, over time, a larger amount is
 4 needed to produce the same physical effect (pain relief) and *physical*
 5 *dependence* – the state defined by the experience of adverse symptoms if a
 6 drug is abruptly withdrawn . . . each of which is common with pain
 7 patients” . . . “and, on the other hand, (2) the psychological and behavioral
 8 patterns – an unhealthy craving for, compulsive use of, and unhealthy
 9 fixation – that characterize *addiction*.²⁸⁷
- 10 • Evidence establishes that the risk of drug addiction (historically the
 11 principal *medical* justification for withholding or limiting opioids) is far
 12 less substantial than long and widely assumed.²⁸⁸
- 13 the addiction. Although the risks are exceedingly low in
 14 older patients with no current or past history of substance
 15 abuse, it is impossible to identify every patient who will
 16 abuse or divert prescribed opioids.¹¹⁷ Therefore, many cli-
 17 nicians have adopted a Universal Precautions approach to
 18 pain management.¹¹⁸ This paradigm stresses that every pa-
- 19 • The “risks [of addiction] are exceedingly low in older patients with no
 20 current or past history of substance abuse.”²⁸⁹

21 ²⁸⁶ Brief of Amici the American Pain Foundation, the National Pain Foundation,
 22 and the National Foundation for the Treatment of Pain, 2005 WL 2405247, *9
 23 (citing Portenoy, Russell, et al., *Acute and Chronic Pain*, in *COMPREHENSIVE*
 24 *TEXTBOOK OF SUBSTANCE ABUSE*, 863-903 (Lowinson et al. eds., 4th ed.
 25 2005), *United States v. Hurwitz*, 459 F.3d 463 (2006) (citing Portenoy et. al.,
 26 *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*,
 27 PAIN, Vol. 25, 171-186, (1986)).

28 ²⁸⁷ Brief of Amici Russel K. Portenoy, et al., 2005 WL 2405249, *United States v.*
 29 *Hurwitz*, 459 F.3d 463 (2006) (emphasis in original).

30 ²⁸⁸ *Id.* and sources cited at note 9.

31 ²⁸⁹ *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.
 32 Geriatrics Soc'y 1331, 1339, 1342 (2009), available at
 33 <https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

1 524. Members of the Opioid Marketing Enterprise advocated that opioids
2 were safe and effective for long-term treatment of chronic, non-acute and non-
3 cancer pain:

4 • “Opioids are an essential option for treating *moderate* to severe pain
5 associated with surgery or trauma. They may also be an important part of
6 the management of persistent pain unrelated to cancer.”²⁹⁰

7 **Clinical uses**

8 Opioids are an essential option for treating moderate to severe pain associated with
9 surgery or trauma, and for pain related to cancer. They may also be an important part of
10 the management of persistent pain unrelated to cancer. These medicines block pain

11 • Opioids were a safe and effective treatment for pain as part of a
12 physicians’ treatment guidelines.²⁹¹

13 • The “small risk of abuse does not justify the withholding of these highly
14 effective analgesics from chronic pain patients.”²⁹²

15 • Opioids, unlike some non-prescription pain medications, are safe at high
16 doses.²⁹³

17 • Falsely representing “recent findings suggesting that most patients are able
18 to successfully remain on long-term opioid therapy without significant
19 problems.”²⁹⁴

20

21 ²⁹⁰ APF, *Treatment Options*,
22 <https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>.

23 ²⁹¹ Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in
24 Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

25 ²⁹² Brief Amici Curiae of American Pain Foundation, National Foundation for the
26 Treatment of Pain, and The Ohio Pain Initiative, in Support of
27 Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA
28 2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),
 <https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

29 ²⁹³ Portenoy, et al., *Overview of Management Options*, <https://cme.ama-assn.org/activity/1296783/detail.aspx>. On information and belief, this CME was published in 2003, 2007, 2010, and 2013.

30 ²⁹⁴ *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0-SF*, PainEdu.org, 2008, <https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf> (last accessed on March 8, 2018).

- 1 • Opioid therapy is an appropriate treatment for chronic, non-cancer pain and
2 integral to good medical practice.²⁹⁵
- 3 • Even for patients assessed to have a risk of abuse, “it does not mean that
4 opioid use will become problematic or that opioids are contraindicated.”²⁹⁶
- 5 • Opioid therapy is an appropriate treatment for chronic, non-cancer pain and
6 integral to good medical practice.²⁹⁷
- 7 • Broadly classifying pain syndromes as “either cancer- or non-cancer-related
8 has limited utility,” and recommended dispensing rapid onset opioids “in
9 patients with non-cancer pain.”²⁹⁸

10 The data suggest that FEBT is safe and well tolerated in opioid-tolerant patients
11 with chronic noncancer pain. There was no respiratory depression, and a low
12 incidence of treatment-related adverse events was reported. Thirty-five patients
13 (37%) reported having at least 1 adverse event, the most common of which were
14 nausea (7%) and dizziness (5%).

- 15 • Opioids are safe and well-tolerated in patients with chronic pain and break
16 through pain.²⁹⁹
- 17 • Non-opioid analgesics and combination opioids containing non-opioids
18 such as aspirin and acetaminophen are less effective than opioids because of
19 dose limitations on non-opioids.³⁰⁰

20 ²⁹⁵ Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9
21 (Waterford Life Sciences 2007).

22 ²⁹⁶ *Id.*

23 ²⁹⁷ Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9 (Waterford Life
24 Sciences 2007).

25 ²⁹⁸ Perry G Fine, MD, et al. *Opioid-Based Management of Persistent and*
26 *Breakthrough Pain*, Pain Medicine News,
27 [https://www.yumpu.com/en/document/view/11409251/opioid-based-management-](https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain)
28 [of-persistent-and-breakthrough-pain](https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain) (accessed on February 27, 2018).

29 ²⁹⁹ Hale ME, Webster LR, Peppin JF, Messina J. Open-label study of fentanyl
30 effervescent buccal tablets in patients with chronic pain and breakthrough pain:
31 interim safety and tolerability results. Program and abstracts of the annual meeting
32 of the American Academy of Pain Medicine; February 22-25, 2006; San Diego,
33 California. Abstract 120. Published with permission of Lynn R. Webster, MD,
34 https://www.medscape.org/viewarticle/524538_2 (accessed on March 6, 2018).

adverse events. Furthermore, although nonopioid analgesics, such as acetaminophen and NSAIDs/COX-2 inhibitors, are effective for nociceptive pain, their use in BTP is likewise restricted by dose-limiting toxicities, an onset of action that is delayed by 30 minutes or more, a long duration of action that could augment sedation and other side effects of the agent used for the baseline pain, and fears about renal and cardiovascular complications. Agents that combine an SAO, such as hydrocodone plus acetaminophen, aspirin, or ibuprofen, also are limited by potential adverse events and ceiling effects from the nonopioid component.

- Opioids can safely alleviate chronic pain unresponsive to other medication.³⁰¹
- Medical organization and government-sponsored clinical guidelines support and encourage opioid treatment for chronic pain.³⁰²
- Respiratory depression, even at extremely high levels, does not occur in the context of appropriate clinical treatment.³⁰³
- There is no “ceiling dose” for opioids.³⁰⁴
- Opioid analgesics are the most effective way to treat pain of moderate to severe intensity and often the only treatment that provides significant relief.³⁰⁵
- “Opioid rotations” (switching from one opioid to another) not only for cancer patients, but also for non-cancer patients, may need to occur four or five times over a person’s “lifetime” to manage pain.³⁰⁶

³⁰⁰ Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, Medscape, http://www.medscape.org/viewarticle/563417_6 (last visited Dec. 11, 2017).

³⁰¹ Brief of Amici the American Pain Foundation, the National Pain Foundation, and the National Foundation for the Treatment of Pain, 2005 WL 2405247, *8, *United States v. Hurwitz*, 459 F.3d 463 (2006) (citing Portenoy et. al, *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*, PAIN, Vol. 25, 171-186, (1986)).

³⁰² *Id.* at *8, and sources cited in note 11.

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ Brief of Amici Russel K. Portenoy, et al., 2005 WL 2405249, *United States v. Hurwitz*, 459 F.3d 463.

1 • Opioids represent a highly effective . . . class of analgesic medications for
2 controlling both chronic and acute pain. The phenomenon of tolerance to
3 opioids – the gradual waning of relief at a given dose – and fears of abuse,
4 diversion, and misuse of these medications by patients have led many
5 clinicians to be wary of prescribing these drugs, and/or to restrict dosages to
6 levels that may be insufficient to provide meaningful relief.³⁰⁷

7 Opioids represent a highly effective but controversial and often misunder-
8 stood class of analgesic medications for controlling both chronic and acute
9 pain. The phenomenon of tolerance to opioids—the gradual waning of relief at
10 a given dose—and fears of abuse, diversion, and misuse of these medications
11 by patients have led many clinicians to be wary of prescribing these drugs,
12 and/or to restrict dosages to levels that may be insufficient to provide mean-
13 ingful relief.³

14 525. Members of the Opioid Marketing Enterprise created and
15 championed the concept of “pseudoaddiction,” advocating that signs of addiction
16 were actually pseudoaddiction that required prescribing additional opioids:
17
18
19
20
21
22
23
24
25

26 ³⁰⁶ Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),
27 https://www.youtube.com/watch?v=_G3II9yqgXI.

28 ³⁰⁷ Charles E. Argoff, *Case Challenges in Pain Management: Opioid Therapy for Chronic Pain*, Pain Med. News, 2007,
29 https://www.painmedicinewebs.com/download/BtoB_Opana_WM.pdf (last visited on March 8, 2018).

1 **WHAT SHOULD I KNOW ABOUT**
2 **OPIOIDS AND ADDICTION?**

3 You or your family may have questions about
4 addiction. It is important to understand what
5 addiction is. Addiction **IS** a chronic brain dis-
6 ease that can occur in some people exposed
7 to certain substances such as alcohol,
8 cocaine, and opioids. Taking opioids for pain
9 relief is not addiction. People addicted to opi-
10 oids crave the opioid and use it regularly for
11 reasons other than pain relief.

12 Addiction **IS NOT** when a person develops
13 "withdrawal" (such as abdominal cramping
14 or sweating) after the medicine is stopped
15 quickly or the dose is reduced by a large
16 amount. Your doctor will avoid stopping your
17 medication suddenly by slowly reducing the
18 amount of opioid you take before the medi-
19 cine is completely stopped. Addiction also
20 **IS NOT** what happens when some people
21 taking opioids need to take a higher dose
22 after a period of time in order for it to contin-
23 ue to relieve their pain. This normal "toler-
24 ance" to opioid medications doesn't affect
25 everyone who takes them and does not, by
26 itself, imply addiction. If tolerance does
27 occur, it does not mean you will "run out" of
28 pain relief. Your dose can be adjusted or
 another medicine can be prescribed.

19

20 • Patients might experience withdrawal symptoms associated with physical
21 dependence as the decrease their dose, "[b]ut unlike actual addicts, such
22 individuals, if they resume their opioid use, will only take enough
23 medication to alleviate their pain."³⁰⁸

24

25

26 ³⁰⁸ Brief Amici Curiae of American Pain Foundation, National Foundation for the
27 Treatment of Pain, and The Ohio Pain Initiative, in Support of
28 Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA
 2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),
 <https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

- 1 ● “Addiction **IS NOT** when a person develops ‘withdrawal’ (such as
2 abdominal cramping or sweating) after the medicine is stopped or the dose
3 is reduced by a large amount. . . . Addiction also **IS NOT** what happens
4 when some people taking opioids need to take a higher dose after a period
5 of time in order for it to continue to relieve their pain. This normal
6 ‘tolerance’ to opioid medications doesn’t affect everyone who takes them
7 and does not, by itself, imply addiction.”³⁰⁹
- 8 ● “Addiction to an opioid would mean that your pain has gone away but you
9 still take the medicine regularly when you don’t need it for pain, maybe just
10 to escape your problems.”³¹⁰

11 *How can I be sure I’m not addicted?*

- 12 ◆ Addiction to an opioid would mean that
13 your pain has gone away but you still
14 take the medicine regularly when you
15 don’t need it for pain, maybe just to
16 escape from your problems.
- 17 ◆ Ask yourself: Would I want to take this
18 medicine if my pain went away? If you
19 answer no, you are taking opioids for
20 the right reasons—to relieve your pain
21 and improve your function. You are not
22 addicted.
- 23 ● Behaviors such as “[r]equesting [drugs] by name,” “[d]emanding or
24 manipulative behavior,” “[o]btaining drugs from more than one physician,”
25 and “[h]oarding opioids,” are all really signs of pseudoaddiction, rather than
26 genuine addiction.”³¹¹

27

³⁰⁹ Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral
28 Opioid Analgesics*, Endo Pharmaceuticals (2004),
http://www.thblack.com/links/RSD/Understand_Pain_Opioid_Analgesics.pdf
(emphasis in original) (last accessed on March 9, 2018).

29 ³¹⁰ *Id.*

30 ³¹¹ Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9
31 (Waterford Life Sciences 2007).

1 • “Sometimes people behave as if they are addicted, when they are really in
2 need of more medication.”³¹²

3 • **ADDICTION** - A craving that
4 drives a person to take an
5 opioid even though it causes
6 harm. This is a problem that
7 needs immediate treatment.
8 This happens to some patients
9 who use opioids.

10 Sometimes people behave as
11 if they are addicted, when they
12 are really in need of more
13 medication. This can be treated
14 with higher doses of medicine.

15 • For prescribers facing signs of aberrant behavior, increasing the does “in
16 most cases . . . should be the clinician’s first response.”³¹³

17 526. Members of the Opioid Marketing Enterprise advocated that long-
18 term use of prescription opioids would improve function, including but not limited
19 to, psychological health, and health-related quality of life:

20
21
22
23
24
25
26

³¹² *Pain: Opioid Facts*,
27 http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380_b385%20%20pf%20opiod.pdf (last
28 visited March 6, 2018).

29 ³¹³ Lynn Webster & Beth Dove, Avoiding Opioid Abuse While Managing Pain
(2007).

Because of their long history of use, the clinical profile of opioids has been very well characterized. Multiple clinical studies have shown that long-acting opioids, in particular, are effective in improving:

- Daily function
- Psychological health
- Overall health-related quality of life for people with chronic pain.¹²

- When opioids are managed, properly prescribed and taken as directed, they are effective in improving daily function, psychological health and health-related quality of life.³¹⁴
- Opioid therapy to relieve pain and improve function is a legitimate medical practice for acute and chronic pain of both cancer and non-cancer origins.³¹⁵
- “[Y]our level of function should improve, you may find you are now able to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy when your pain was worse.”³¹⁶
- “The goal of opioid therapy is to . . . improve your function.”³¹⁷

The goal of opioid therapy is to control pain and improve your function.

³¹⁴ A Policymaker’s Guide to Understanding Pain & Its Management, American Pain Foundation (2011) at

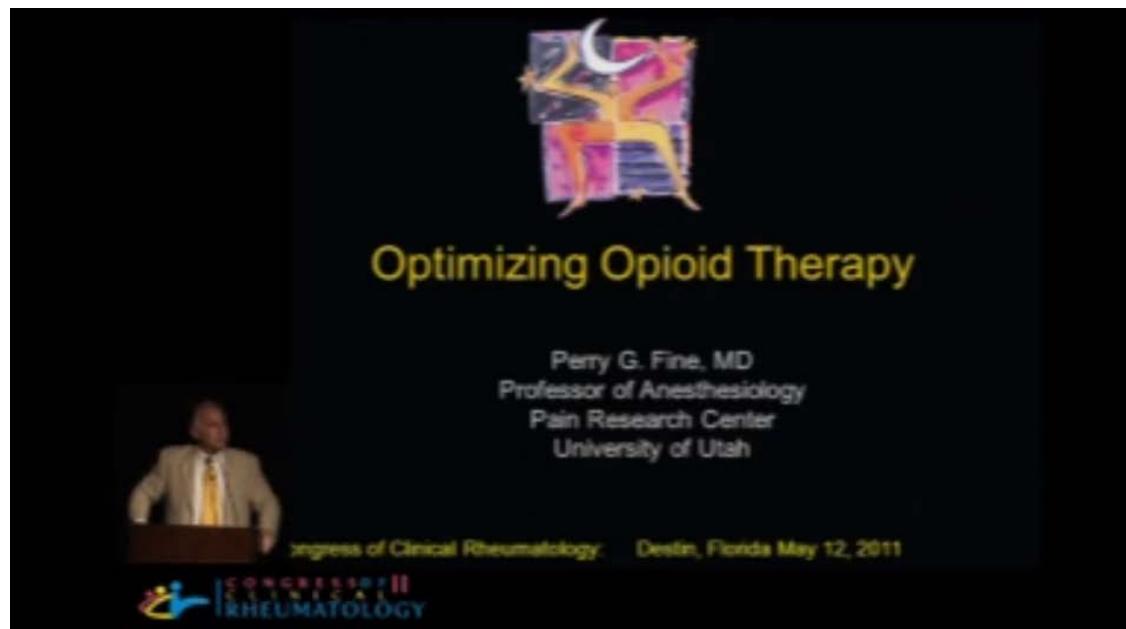
5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

³¹⁵ Scott M. Fishman, Responsible Opioid Prescribing: A Physician’s Guide, 8-9 (Waterford Life Sciences 2007); Scott M. Fishman, *Responsible Opioid Prescribing: A Clinician’s Guide*, 10-11 (2d ed. 2012).

³¹⁶ Plaintiffs are informed and believe that this misrepresentation was made on the website painknowledge.org.

³¹⁷ *Pain: Opioid Facts*, http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380_b385%20%20pf%20opioid.pdf (last visited March 6, 2018).

- The “goal” for chronic pain patients is to “improve effectiveness which is different from efficacy and safety.”³¹⁸



13 527. Members of the Opioid Marketing Enterprise represented that
14 screening questions and professional guidelines would help curb addiction and
15 potential abuse:

- Screening questions and professional guidelines will “easily and efficiently” allow physicians to manage risk and “minimize the potential for abuse.”³¹⁹
- Risk screening tools, urine testing, and patient agreements are a way to prevent “overuse of prescriptions” and “overdose deaths.”³²⁰

²⁴ ³¹⁸ Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012), https://www.youtube.com/watch?v=_G3II9yqgXI.

²⁵ ³¹⁹ Scott M. Fishman, *Responsible Opioid Prescribing: A Physician's Guide*, 8-9 (Waterford Life Sciences 2007).

³²⁰ See, *Managing Patient's Opioid Use: Balancing the Need and the Risk*, Emerging Solutions in Pain http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209 (last visited Aug. 22, 2017).

1 **Program Overview**

2 Compliance with regulatory and policy-driven authorities mandates improvement in the treatment of patients on chronic opioid therapy (COT) to
3 ensure that the best possible care is provided to pain patients while minimizing potential risk of inappropriate use. Participants of this activity will
4 be able to evaluate current issues in appropriate patient selection and management of chronic pain patients treated with COT including a review
5 of the most current Risk Evaluation and Mitigation Strategies (REMS) requirements, updates in the development of novel delivery systems and
6 the practical application of assessment tools to assist in their daily practice.

- 7 • The risks of addiction and abuse can be managed by doctors and evaluated
8 with “tools.”³²¹

9 528. In addition to the unbranded marketing misrepresentations made by
10 members of the Opioid Marketing Enterprise, the RICO Marketing Defendants
11 made misrepresentations in their branded marketing activities. The RICO
12 Marketing Defendants’ branded marketing misrepresentations furthered the
13 common purpose of the Opioid Marketing Enterprise because they advanced the
14 common messages of the Opioid Marketing Enterprise. For example:

15 529. The RICO Marketing Defendants misrepresented that opioids were
16 non-addictive or posed less risk of addiction or abuse:

- 17 • Purdue:
 - 18 ○ “Fear of addiction is exaggerated.”³²²

26

27 ³²¹ Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),
28 https://www.youtube.com/watch?v=_G3II9yqgXI.

27 ³²² Harriet Ryan, et al., “*You Want A Description of Hell?*” *OxyContin’s 12-Hour Problem*, L.A. Times (May 5, 2016), <http://documents.latimes.com/oxycontin-press-release-1996/> (hereinafter “Ryan, Description of Hell”).

1 The fear of addiction is exaggerated.

2 One cause of patient resistance to appropriate pain treatment – the
3 fear of addiction – is largely unfounded. According to Dr. Max,
4 "Experts agree that most pain caused by surgery or cancer can be
5 relieved, primarily by carefully adjusting the dose of opioid
6 (narcotic) pain reliever to each patient's need, and that there is very
7 little risk of addiction from the proper uses of these drugs for pain
8 relief."

9 Paul D. Goldenheim, M.D., Vice President of **Purdue Pharma L.P.** in
10 Norwalk, Connecticut, agrees with this assessment. "Proper use of
11 medication is an essential weapon in the battle against persistent
12 pain. But too often fear, misinformation and poor communication stand
13 in the way of their legitimate use."

14 o "[W]e've discovered that the simplicity and convenience of twice-
15 daily dosing also enhances patient compliance with their doctor's
16 instructions."³²³

17 taking tablets every four to six hours. Moreover, we've discovered that
18 the simplicity and convenience of twice-daily dosing also enhances

19 https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23_T23962617276&format=GNBF

20 [REDACTED]

21 1/27/2016

22 patient compliance with their doctor's instructions."

23 o Long-acting, extended release formulations are safe and "less prone"
24 to abuse by patients and addiction.³²⁴

25 o OxyContin is safe and non-addictive when using extended release
26 formulations, and appropriate for use in non-cancer patients.³²⁵

27

³²³ *Id.*

28 ³²⁴ Barry Meier, *In Guilty Plea, OxyContin Maker to Pay \$600 Million*, N.Y.
29 Times (May 10, 2007), <http://www.nytimes.com/2007/05/10/business/11drug-web.html> (hereinafter "Meier, Guilty Plea").

30 ³²⁵ Charles Ornstein & Tracy Weber, *American Pain Foundation Shuts Down as
31 Senators Launch Investigation of Prescription Narcotics*, ProPublica (May 8,
32 2012, 8:57 PM),
33 http://www.opb.org/news/article/america_pain_foundation_shuts_down_as_senato

- 1 ○ Consistently minimizing the risk of addiction in the use of opioids for
- 2 the treatment of chronic non-cancer-related pain.³²⁶
- 3 ○ OxyContin is virtually non-addicting.³²⁷
- 4 ○ “Assur[ing] doctors – repeatedly and without evidence – that ‘fewer
- 5 than one percent’ of patients who took OxyContin became
- 6 addicted.”³²⁸



- 17 ○ OxyContin was addiction resistant and had “abuse-deterrent
- 18 properties.”³²⁹
- 19 ○ Misrepresented the risk of addiction using misleading and inaccurate
- 20 promotions of OxyContin that were unsupported by science.³³⁰

21
22 rs_launch_investigation_of_prescription_narcotics/ (hereinafter “Ornstein,
23 American Pain Foundation”).

24 ³²⁶ Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial*
25 *Triumph, Public Health Tragedy*, 99(2) Am. J. Pub. Health 221-27 (Feb. 2009)
26 (hereinafter, “Van Zee, Promotion and Marketing”).

27 ³²⁷ Patrick Keefe, *The Family that Built an Empire of Pain*, New Yorker (Oct. 30,
28 2017), <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>

29 ³²⁸ *Id.*; see also “*I got my life back*,” OxyContin Promotional Video, 1998,
30 <https://www.youtube.com/watch?v=Er78Dj5hyeI> (last accessed on March 8,
31 2018).

32 ³²⁹ *Id.*

- 1 ○ It was more difficult to extract the oxycodone from an OxyContin
2 tablet for intravenous abuse.³³¹
- 3 ○ OxyContin created fewer chances for addiction than immediate-
4 release opioids.³³²
- 5 ○ OxyContin had fewer “peak and trough” effects than immediate-
6 release opioids resulting in less euphoria and less potential for abuse
7 than short-acting opioids.³³³
- 8 ○ Patients could abruptly stop opioid therapy without experiencing
9 withdrawal symptoms, and patients who took OxyContin would not
10 develop tolerance.³³⁴
- 11 ○ OxyContin did not cause a “buzz,” caused less euphoria, had less
12 addiction potential, had less abuse potential, was less likely to be
13 diverted than immediate-release opioids, and could be used to “weed
14 out” addicts and drug seekers.³³⁵
- 15 ○ Purdue published a prescriber and law enforcement education
16 pamphlet in 2011 entitled *Providing Relief, Preventing Abuse*, which
17 under the heading, “Indications of Possible Drug Abuse,” shows
18 pictures of the stigmata of injecting or snorting opioids—skin
19 popping, track marks, and perforated nasal septa. In fact, opioid
20 addicts who resort to these extremes are uncommon; the far more
21 typical reality is patients who become dependent and addicted

23 ³³⁰ Press Release, U.S. Attorney for the Western District of Virginia, Statement of
24 United States Attorney John Brownlee on the Guilty Plea of the Purdue Frederick
25 Company and Its Executives for Illegally Misbranding OxyContin (May 10, 2007),
<https://assets.documentcloud.org/documents/279028/purdue-guilty-plea.pdf>.

26 ³³¹ *Id.*

27 ³³² *Id.*

28 ³³³ *Id.*

³³⁴ *Id.*

³³⁵ *Id.*

1 through oral use. Thus, these misrepresentations wrongly reassured
 2 doctors that as long as they do not observe those signs, they need not
 3 worry that their patients are abusing or addicted to opioids.

- 4 ○ Purdue sponsored APF's *A Policymaker's Guide to Understanding*
 5 *Pain & Its Management*, which inaccurately claimed that less than
 6 1% of children prescribed opioids will become addicted. This
 7 publication is still available online. This publication also asserted that
 8 pain is undertreated due to "misconceptions about opioid addiction."
- 9 ○ Purdue sponsored APF's *Treatment Options: A Guide for People*
 10 *Living with Pain* (2007), which asserted that addiction is rare and
 11 limited to extreme cases of unauthorized dose escalations, obtaining
 12 opioids from multiple sources, or theft.
- 13 ○ A Purdue-funded study with a Purdue co-author claimed that
 14 "evidence that the risk of psychological dependence or addiction is
 15 low in the absence of a history of substance abuse."³³⁶ The study
 16 relied only on the 1980 Porter-Jick letter to the editor concerning a
 17 chart review of hospitalized patients, not patients taking Purdue's
 18 long-acting, take-home opioid. Although the term "low" is not
 19 defined, the overall presentation suggests the risk is so low as not to
 20 be a worry.
- 21 ○ Purdue contracted with AGS to produce a CME promoting the 2009
 22 guidelines for the *Pharmacological Management of Persistent Pain*
 23 in *Older Persons*. These guidelines falsely claim that "the risks [of
 24 addiction] are exceedingly low in older patients with no current or
 25 past history of substance abuse." None of the references in the
 26

27 ³³⁶ C. Peter N. Watson et al., Controlled-release oxycodone relieves neuropathic
 28 pain: a randomized controlled trial I painful diabetic neuropathy, 105 Pain 71
 (2003).

1 guidelines corroborates the claim that elderly patients are less likely
2 to become addicted to opioids and the claim is, in fact, untrue. Purdue
3 was aware of the AGS guidelines' content when it agreed to provide
4 this funding, and AGS drafted the guidelines with the expectation it
5 would seek drug company funding to promote them after their
6 completion.

- 7 ○ Purdue sponsored APF's *Exit Wounds* (2009), which counseled
8 veterans that “[l]ong experience with opioids shows that people who
9 are not predisposed to addiction are very unlikely to become addicted
10 to opioid pain medications.” Although the term “very unlikely” is not
11 defined, the overall presentation suggests it is so low as not to be a
12 worry.
- 13 ○ Purdue sales representatives told prescribers that its drugs were
14 “steady state,” the implication of which was that they did not produce
15 a rush or euphoric effect, and therefore were less addictive and less
16 likely to be abused.
- 17 ○ Purdue sales representatives told prescribers that Butrans has a lower
18 abuse potential than other drugs because it was essentially
19 tamperproof and, after a certain point, patients no longer experience a
20 “buzz” from increased dosage.
- 21 ○ Advertisements that Purdue sent to prescribers stated that OxyContin
22 ER was less likely to be favored by addicts, and, therefore, less likely
23 to be abused or diverted, or result in addiction.
- 24 ○ In discussions with prescribers, Purdue sales representatives omitted
25 discussion of addiction risks related to Purdue’s drugs.

26 • Janssen:
27 ○ **Myth:** Opioid medications are always addictive.
28

1 **Fact:** Many studies show that opioids are rarely addictive when used
 2 properly for the management of chronic pain.³³⁷

3 ○ **Myth:** Opioid doses have to get bigger over time because the body
 4 gets used to them.

5 **Fact:** Unless the underlying cause of your pain gets worse (such as
 6 with cancer or arthritis), you will probably remain on the same dose
 7 or need only small increases over time.³³⁸

8 ○ “[Q]uestions of addiction,” “are often overestimated” because,
 9 “[a]ccording to clinical opinion polls, true addiction occurs only in a
 10 small percentage of patients with chronic pain who receive chronic
 11 opioid analgesics.”³³⁹

12 *Other Opioid Analgesic Concerns*

13 Aside from medical issues related to opioid analgesics, there are nonmedical
 14 issues that may have an impact on prescribing patterns and patient use of
 15 these drugs. Practitioners are often concerned about prescribing opioid
 16 analgesics due to potential legal issues and **questions of addiction**.^{15,16} By
 17 the same token, patients report similar concerns about developing an
 18 addiction to opioid analgesics.¹⁷ While these concerns are not without some
 19 merit, it would appear that they are often overestimated. According to clinical
 20 opinion polls, true addiction occurs only in a small percentage of patients
 21 with chronic pain who receive chronic opioid analgesics analgesic therapy.¹⁸

22 ○ Janssen sponsored a patient education guide titled *Finding Relief:*
 23 *Pain Management for Older Adults* (2009), which its personnel
 24 reviewed and approved and which its sales force distributed. This
 25 guide described a “myth” that opioids are addictive, and asserts as
 26 fact that “[m]any studies show that opioids are rarely addictive when

27 ³³⁷ Finding Relief, Pain Management for Older Adults, (2009) (emphasis in
 28 original).

29 ³³⁸ Finding Relief, Pain Management for Older Adults, (2009) (emphasis in
 30 original).

31 ³³⁹ *Use of Opioid Analgesics in Pain Management*, Prescribe Responsibly,
 32 <http://www.prescriberesponsibly.com/articles/opioid-pain-management> (last
 33 visited Dec. 11, 2017).

1 used properly for the management of chronic pain.” Although the
2 term “rarely” is not defined, the overall presentation suggests the risk
3 is so low as not to be a worry. The language also implies that as long
4 as a prescription is given, opioid use is not a problem.

5 ○ Janssen contracted with AGS to produce a CME promoting the 2009
6 guidelines for the *Pharmacological Management of Persistent Pain*
7 in *Older Persons*. These guidelines falsely claim that “the risks [of
8 addiction] are exceedingly low in older patients with no current or
9 past history of substance abuse.” The study supporting this assertion
10 does not analyze addiction rates by age and, as already noted,
11 addiction remains a significant risk for elderly patients. Janssen was
12 aware of the AGS guidelines’ content when it agreed to provide this
13 funding, and AGS drafted the guidelines with the expectation it
14 would seek drug company funding to promote them after their
15 completion.

16 ○ Janssen provided grants to APF to distribute *Exit Wounds* (2009) to
17 veterans, which taught that “[l]ong experience with opioids shows that
18 people who are not predisposed to addiction are very unlikely to
19 become addicted to opioid pain medications.” Although the term
20 “very unlikely” is not defined, the overall presentation suggests the
21 risk is so low as not to be a worry.

22 ○ Janssen currently runs a website, Prescriberesponsibly.com (last
23 modified July 2, 2015), which claims that concerns about opioid
24 addiction are “overstated.”

25 ○ A June 2009 Nucynta Training module warns Janssen’s sales force
26 that physicians are reluctant to prescribe controlled substances like
27 Nucynta, but this reluctance is unfounded because “the risks . . . are
28 much smaller than commonly believed.”

- 1 ○ Janssen sales representatives told prescribers that its drugs were
2 “steady state,” the implication of which was that they did not produce
3 a rush or euphoric effect, and therefore were less addictive and less
4 likely to be abused.
- 5 ○ Janssen sales representatives told prescribers that Nucynta and
6 Nucynta ER were “not opioids,” implying that the risks of addiction
7 and other adverse outcomes associated with opioids were not
8 applicable to Janssen’s drugs. In truth, however, as set out in
9 Nucynta’s FDA-mandated label, Nucynta “contains tapentadol, an
10 opioid agonist and Schedule II substance with abuse liability similar
11 to other opioid agonists, legal or illicit.”
- 12 ○ Janssen’s sales representatives told prescribers that Nucynta’s unique
13 properties eliminated the risk of addiction associated with the drug.
- 14 ○ In discussions with prescribers, Janssen sales representatives omitted
15 discussion of addiction risks related to Janssen’s drugs.

16 ● Cephalon:

- 17 ○ Cephalon sponsored and facilitated the development of a guidebook,
18 *Opioid Medications and REMS: A Patient’s Guide*, which claims,
19 among other things, that “patients without a history of abuse or a
20 family history of abuse do not commonly become addicted to
21 opioids.”
- 22 ○ Cephalon sponsored APF’s *Treatment Options: A Guide for People*
23 *Living with Pain* (2007), which taught that addiction is rare and
24 limited to extreme cases of unauthorized dose escalations, obtaining
25 opioids from multiple sources, or theft.
- 26 ○ In discussions with prescribers, Cephalon sales representatives
27 omitted any discussion of addiction risks related to Cephalon’s drugs.

1 • Endo:

2 ○ Opana ER was designed to be crush resistant

3 ○ Opana ER was crush and abuse resistant and not addictive.³⁴⁰

4 ○ “[T]he Reformulated Opana ER as ‘designed to be’ crush

5 resistant.”³⁴¹

6 ○ “[P]atients treated with prolonged opioid medicines usually do not

7 become addicted.”³⁴²

8 ○ Endo trained its sales force in 2012 that use of long-acting opioids

9 resulted in increased patient compliance, without any supporting

10 evidence.

11 ○ Endo’s advertisements for the 2012 reformulation of Opana ER

12 claimed it was designed to be crush resistant, in a way that conveyed

13 that it was less likely to be abused. This claim was false; the FDA

14 warned in a May 10, 2013 letter that there was no evidence Endo’s

15 design “would provide a reduction in oral, intranasal or intravenous

16 abuse” and Endo’s “post-marketing data submitted are insufficient to

17 support any conclusion about the overall or route-specific rates of

18 abuse.” Further, Endo instructed its sales representatives to repeat

19 this claim about “design,” with the intention of conveying Opana ER

20 was less subject to abuse.

21

22

23

24 ³⁴⁰ *In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc.*,
25 Assurance No. 15-228, Assurance of Discontinuance Under Executive Law
26 Section 63, Subdivision 15, at 5 (Mar. 1, 2016),
27 https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf.

28 ³⁴¹ *Id.* at 6.

29 ³⁴² *In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc.*,
30 Assurance No. 15-228, Assurance of Discontinuance Under Executive Law
31 Section 63, Subdivision 15, at 5 (Mar. 1, 2016),
32 https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf.

- 1 ○ Endo sponsored a website, painknowledge.com, through APF and
- 2 NIPC, which claimed in 2009 that: “[p]eople who take opioids as
- 3 prescribed usually do not become addicted.” Although the term
- 4 “usually” is not defined, the overall presentation suggests the risk is
- 5 so low as not to be a worry. The language also implies that as long as
- 6 a prescription is given, opioid use will not become problematic. Endo
- 7 continued to provide funding for this website through 2012, and
- 8 closely tracked unique visitors to it.
- 9 ○ Endo sponsored a website, PainAction.com, which stated “Did you
- 10 know? Most chronic pain patients do not become addicted to the
- 11 opioid medications that are prescribed for them.”
- 12 ○ Endo sponsored CMEs published by APF’s NIPC, of which Endo
- 13 was the sole funder, titled *Persistent Pain in the Older Adult* and
- 14 *Persistent Pain in the Older Patient*. These CMEs claimed that
- 15 opioids used by elderly patients present “possibly less potential for
- 16 abuse than in younger patients[,]” which lacks evidentiary support
- 17 and deceptively minimizes the risk of addiction for elderly patients.
- 18 ○ Endo distributed an education pamphlet with the Endo logo titled
- 19 *Living with Someone with Chronic Pain*, which inaccurately
- 20 minimized the risk of addiction: “Most health care providers who
- 21 treat people with pain agree that most people do not develop an
- 22 addiction problem.”
- 23 ○ Endo distributed a patient education pamphlet edited by key opinion
- 24 leader Dr. Russell Portenoy titled *Understanding Your Pain: Taking*
- 25 *Oral Opioid Analgesics*. It claimed that “[a]ddicts take opioids for
- 26 other reasons [than pain relief], such as unbearable emotional
- 27
- 28

1 problems.” This implies that pain patients prescribed opioids will not
 2 become addicted, which is unsupported and untrue.

- 3 ○ Endo contracted with AGS to produce a CME promoting the 2009
 4 guidelines for the *Pharmacological Management of Persistent Pain*
 5 in *Older Persons*. These guidelines falsely claim that “the risks [of
 6 addiction] are exceedingly low in older patients with no current or
 7 past history of substance abuse.” None of the references in the
 8 guidelines corroborates the claim that elderly patients are less likely
 9 to become addicted to opioids, and there is no such evidence. Endo
 10 was aware of the AGS guidelines’ content when it agreed to provide
 11 this funding, and AGS drafted the guidelines with the expectation it
 12 would seek drug company funding to promote them after their
 13 completion.
- 14 ○ Endo sales representatives told prescribers that its drugs were “steady
 15 state,” the implication of which was that they did not produce a rush
 16 or euphoric effect, and therefore were less addictive and less likely to
 17 be abused.
- 18 ○ Endo provided grants to APF to distribute *Exit Wounds* (2009) to
 19 veterans, which taught that “[l]ong experience with opioids shows
 20 that people who are not predisposed to addiction are very unlikely to
 21 become addicted to opioid pain medications.” Although the term
 22 “very unlikely” is not defined, the overall presentation suggests that
 23 the risk is so low as not to be a worry.
- 24 ○ In discussions with prescribers, Endo sales representatives omitted
 25 discussion of addiction risks related to Endo’s drugs.

27 530. The RICO Marketing Defendants misrepresented that opioids
 28 improved function and quality of life:

1 • Purdue:

2 ◦ “[W]e’ve discovered that the simplicity and convenience of twice-
3 daily dosing also enhances patient compliance with their doctor’s
4 instructions.”³⁴³

5
6 taking tablets every four to six hours. Moreover, we’ve discovered that
7 the simplicity and convenience of twice-daily dosing also enhances

8 https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23_T23962617276&format=GNBF

9
10 /27/2016

11 patient compliance with their doctor’s instructions.”

12 ◦ Purdue ran a series of advertisements for OxyContin in 2012 in
13 medical journals titled “Pain vignettes,” which were case studies
14 featuring patients, each with pain conditions persisting over several
15 months, recommending OxyContin for each. One such patient,
16 “Paul,” is described to be a “54-year-old writer with osteoarthritis of
17 the hands,” and the vignettes imply that an OxyContin prescription
18 will help him work more effectively.

19 ◦ Purdue sponsored APF’s *A Policymaker’s Guide to Understanding*
20 *Pain & Its Management*, which inaccurately claimed that “multiple
21 clinical studies” have shown that opioids are effective in improving
22 daily function, psychological health, and health-related quality of life
23 for chronic pain patients.” The sole reference for the functional
24 improvement claim noted the absence of long-term studies and
25 actually stated: “For functional outcomes, the other analgesics were

26
27
28 ³⁴³ Ryan, *Description of Hell*, <http://documents.latimes.com/oxycontin-press-release-1996/>

1 significantly more effective than were opioids.” *The Policymaker’s*
 2 *Guide* is still available online.

- 3 ○ Purdue sponsored APF’s Treatment Options: A Guide for People
 4 Living with Pain (2007), which counseled patients that opioids, when
 5 used properly, “give [pain patients] a quality of life we deserve.”
 6 APF distributed 17,200 copies in one year alone, according to its
 7 2007 annual report, and the guide currently is available online.
- 8 ○ Purdue sponsored APF’s *Exit Wounds* (2009), which taught veterans
 9 that opioid medications “increase your level of functioning.” *Exit*
 10 *Wounds* also omits warnings of the risk of interactions between
 11 opioids and benzodiazepines, which would increase fatality risk.
 12 Benzodiazepines are frequently prescribed to veterans diagnosed with
 13 post-traumatic stress disorder.
- 14 ○ Purdue sponsored the FSMB’s Responsible Opioid Prescribing
 15 (2007), which taught that relief of pain itself improved patients’
 16 function. Responsible Opioid Prescribing explicitly describes
 17 functional improvement as the goal of a “long-term therapeutic
 18 treatment course.” Purdue also spent over \$100,000 to support
 19 distribution of the book.

20 • Janssen:

- 21 ○ Misrepresented that patients experienced “[s]ignificantly reduced
 22 nighttime awakenings.”³⁴⁴
- 23 ○ Misrepresented “[s]ignificant improvement in disability scores as
 24 measured by the Oswestry Disability Questionnaire and Pain
 25 Disability Index.”³⁴⁵

27 ³⁴⁴ NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to
 28 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

³⁴⁵ *Id.*

- Misrepresented “[s]ignificant improvement in social functioning.”
- Misrepresented outcome claims that were misleading because they lacked substantial support, evidence or clinical experience and “impl[ied] that patients will experience improved social or physical functioning or improved work productivity when using Duragesic,” including: “1,360 loaves . . . and counting, [w]ork, uninterrupted, [l]ife, uninterrupted, [g]ame, uninterrupted, [c]hronic pain relief that supports functionality, [h]elps patients think less about their pain, and [i]mprove[s] . . . physical and social functioning.”³⁴⁶
- Misrepresented that “[o]pioid analgesics, for example, have no true ‘ceiling dose’ for analgesia and do not cause direct organ damage.”³⁴⁷

Use of Opioid Analgesics in Pain Management

Opioid analgesics are often the first line of treatment for many painful conditions and may offer advantages over nonsteroidal anti-inflammatory drugs (NSAIDs). Opioid analgesics, for example, have no true "ceiling dose" for analgesia and do not cause direct organ damage; however, they do have several possible side effects, including constipation, nausea, vomiting, a decrease in sexual interest, drowsiness, and respiratory depression. With the exception of constipation, many patients often develop tolerance to most of the opioid analgesic-related side effects.⁸

- **Myth:** Opioids make it harder to function normally.
- **Fact:** When used correctly for appropriate conditions, opioids may make it easier for people to live normally.³⁴⁸
- Janssen sponsored a patient education guide titled *Finding Relief: Pain Management for Older Adults* (2009), which its personnel reviewed and approved and its sales force distributed. This guide

³⁴⁶ *Id.* at 3 (internal quotations omitted).

³⁴⁷ *Use of Opioid Analgesics in Pain Management*, Prescribe Responsibly, <http://www.prescriberesponsibly.com/articles/opioid-pain-management> (last visited Dec. 11, 2017).

³⁴⁸ *Finding Relief, Pain Management for Older Adults*, (2009) (emphasis in original).

1 features a man playing golf on the cover and lists examples of
2 expected functional improvement from opioids, like sleeping through
3 the night, returning to work, recreation, sex, walking, and climbing
4 stairs. The guide states as a “fact” that “opioids may make it easier
5 for people to live normally” (emphasis in the original). The myth/fact
6 structure implies authoritative backing for the claim that does not
7 exist. The targeting of older adults also ignored heightened opioid
8 risks in this population.

9 ○ Janssen sponsored, developed, and approved content of a website,
10 *Let's Talk Pain* in 2009, acting in conjunction with the APF and
11 AAPM whose participation in Let's Talk Pain Janssen financed and
12 orchestrated. This website featured an interview, which was edited by
13 Janssen personnel, claiming that opioids were what allowed a patient
14 to “continue to function,” inaccurately implying her experience
15 would be representative. This video is still available today on
16 youtube.com.

17 ○ Janssen provided grants to APF to distribute *Exit Wounds* to veterans,
18 which taught that opioid medications “increase your level of
19 functioning” (emphasis in the original). *Exit Wounds* also omits
20 warnings of the risk of interactions between opioids and
21 benzodiazepines, which would increase fatality risk. Benzodiazepines
22 are frequently prescribed to veterans diagnosed with post-traumatic
23 stress disorder.

24 • Cephalon:

25 ○ Cephalon sponsored the FSMB’s Responsible Opioid Prescribing
26 (2007), which taught that relief of pain itself improved patients’
27 function. Responsible Opioid Prescribing explicitly describes

1 functional improvement as the goal of a “long-term therapeutic
 2 treatment course.” Cephalon also spent \$150,000 to purchase copies
 3 of the book in bulk and distributed the book through its pain sales
 4 force to 10,000 prescribers and 5,000 pharmacists.

- 5 ○ Cephalon sponsored the American Pain Foundation’s *Treatment*
 6 *Options: A Guide for People Living with Pain* (2007), which taught
 7 patients that opioids when used properly “give [pain patients] a
 8 quality of life we deserve.” The *Treatment Options* guide notes that
 9 non-steroidal anti-inflammatory drugs have greater risks with
 10 prolonged duration of use, but there was no similar warning for
 11 opioids. APF distributed 17,200 copies in one year alone, according
 12 to its 2007 annual report, and the publication is currently available
 13 online.
- 14 ○ Cephalon sponsored a CME written by Dr. Webster, titled
 15 Optimizing Opioid Treatment for Breakthrough Pain, which was
 16 offered online by Medscape, LLC from September 28, 2007, through
 17 December 15, 2008. The CME taught that Cephalon’s Actiq and
 18 Fentora improve patients’ quality of life and allow for more activities
 19 when taken in conjunction with long-acting opioids.

20 ● Endo:

- 21 ○ Opana ER “will benefit patients, physicians and payers.”³⁴⁹

22 “Patient safety is our top concern and addressing appropriate use of opioids is a responsibility
 23 that we take very seriously. We firmly believe this new formulation of Opana ER, coupled with
 24 our long-term commitment to awareness and education around appropriate use of opioids will
 25 benefit patients, physicians and payers.”

26
 27 ³⁴⁹ *FDA Approves Endo Pharmaceuticals’ Crush-Resistant Opana ER*, December
 28 12, 2011, [https://www.biopharm.com/article/releases/fda-approves-endo-](https://www.biopharm.com/article/releases/fda-approves-endo-pharmaceuticals-crush-resistant-pana-er/)
 pharmaceuticals-crush-resistant-pana-er/-.

- 1 ○ “Endo distributed a pamphlet in New York and posted on its public
- 2 website, www.opana.com, photographs of purported Opana ER
- 3 patients that implied that patients can achieve higher function with
- 4 Opana ER.”³⁵⁰
- 5 ○ Endo sponsored a website, painknowledge.com, through APF and
- 6 NIPC, which claimed in 2009 that with opioids, “your level of
- 7 function should improve; you may find you are now able to
- 8 participate in activities of daily living, such as work and hobbies, that
- 9 you were not able to enjoy when your pain was worse.” Endo
- 10 continued to provide funding for this website through 2012, and
- 11 closely tracked unique visitors to it.
- 12 ○ A CME sponsored by Endo, titled *Persistent Pain in the Older*
- 13 *Patient*, taught that chronic opioid therapy has been “shown to reduce
- 14 pain and improve depressive symptoms and cognitive functioning.”
- 15 ○ Endo distributed handouts to prescribers that claimed that use of
- 16 Opana ER to treat chronic pain would allow patients to perform work
- 17 as a chef. This flyer also emphasized Opana ER’s indication without
- 18 including equally prominent disclosure of the “moderate to severe
- 19 pain” qualification.
- 20 ○ Endo’s sales force distributed FSMB’s *Responsible Opioid*
- 21 *Prescribing* (2007). This book taught that relief of pain itself
- 22 improved patients’ function. Responsible Opioid Prescribing
- 23 explicitly describes functional improvement as the goal of a “long-
- 24 term therapeutic treatment course.”
- 25 ○ Endo provided grants to APF to distribute *Exit Wounds* to veterans,
- 26 which taught that opioid medications “increase your level of

³⁵⁰ *Id.* at 8.

1 functioning” (emphasis in the original). Exit Wounds also omits
 2 warnings of the risk of interactions between opioids and
 3 benzodiazepines, which would increase fatality risk. Benzodiazepines
 4 are frequently prescribed to veterans diagnosed with post-traumatic
 5 stress disorder.

6 531. The RICO Marketing Defendants misrepresented that addiction risks
 7 can be avoided or managed through screening tools and prescription guidelines:

- 8 • Purdue:
 - 9 ○ Purdue’s unbranded website, In the Face of Pain
 10 (inthefaceofpain.com) states that policies that “restrict[] access to
 11 patients with pain who also have a history of substance abuse” and
 12 “requiring special government-issued prescription forms for the only
 13 medications that are capable of relieving pain that is severe” are “at
 14 odds with” best medical practices.³⁵¹
 - 15 ○ Purdue sponsored a 2012 CME program taught by a KOL titled
 16 *Chronic Pain Management and Opioid Use: Easing Fears,
 17 Managing Risks, and Improving Outcomes*. This presentation
 18 recommended that use of screening tools, more frequent refills, and
 19 switching opioids could treat a high-risk patient showing signs of
 20 potentially addictive behavior.
 - 21 ○ Purdue sponsored a 2011 webinar taught by Dr. Lynn Webster, titled
 22 *Managing Patient’s Opioid Use: Balancing the Need and Risk*. This
 23 publication taught prescribers that screening tools, urine tests, and
 24

25
 26
 27 ³⁵¹ See In the Face of Pain Fact Sheet: Protecting Access to Pain Treatment, Purdue
 28 Pharma L.P. (Resources verified Mar. 2012),
www.inthefaceofpain.com/content/uploads/2011/12/factsheet_ProtectingAccess.pdf.

1 patient agreements have the effect of preventing “overuse of
2 prescriptions” and “overdose deaths.”

3 ○ Purdue sales representatives told prescribers that screening tools can
4 be used to select patients appropriate for opioid therapy and to
5 manage the risks of addiction.

6 • Cephalon:

7 ○ Cephalon sponsored APF’s *Treatment Options: A Guide for People*
8 *Living with Pain* (2007), which taught patients that “opioid
9 agreements” between doctors and patients can “ensure that you take
10 the opioid as prescribed.”

11 • Endo:

12 ○ Endo paid for a 2007 supplement³⁵² available for continuing
13 education credit in the Journal of Family Practice and written by a
14 doctor who later became a member of Endo’s speakers bureau. This
15 publication, titled *Pain Management Dilemmas in Primary Care: Use of Opioids*, recommended screening patients using tools like the
16 Opioid Risk Tool or the Screener and Opioid Assessment for Patients
17 with Pain, and advised that patients at high risk of addiction could
18 safely (e.g., without becoming addicted) receive chronic opioid
19 therapy using a “maximally structured approach” involving
20 toxicology screens and pill counts.

22 532. The RICO Marketing Defendants misrepresented that signs of opioid
23 addiction were not addiction, withdrawal could be simply managed, and promoted
24 the concept of pseudoaddiction:

25 • Purdue:

27

28 ³⁵² The Medical Journal, *The Lancet* found that all of the supplement papers it received failed peer-review. Editorial, “*The Perils of Journal and Supplement Publishing*,” 375 *The Lancet* 9712 (347) 2010.

- 1 ○ Purdue published a prescriber and law enforcement education
- 2 pamphlet in 2011 entitled *Providing Relief, Preventing Abuse*, which
- 3 described pseudoaddiction as a concept that “emerged in the
- 4 literature to describe the inaccurate interpretation of [drug-seeking]
- 5 behaviors] in patients who have pain that has not been effectively
- 6 treated.”
- 7 ○ Purdue distributed to physicians, at least as of November 2006 and
- 8 posted on its unbranded website, Partners Against Pain, a pamphlet
- 9 copyrighted 2005 and titled *Clinical Issues in Opioid Prescribing*.
- 10 This pamphlet included a list of conduct including “illicit drug use
- 11 and deception” it defined as indicative of pseudoaddiction or
- 12 untreated pain. It also states: “Pseudoaddiction is a term which has
- 13 been used to describe patient behaviors that may occur when pain is
- 14 undertreated. . . . Even such behaviors as illicit drug use and
- 15 deception can occur in the patient’s efforts to obtain relief.
- 16 Pseudoaddiction can be distinguished from true addiction in that the
- 17 behaviors resolve when the pain is effectively treated.”
- 18 ○ Purdue sponsored FSMB’s *Responsible Opioid Prescribing* (2007),
- 19 which taught that behaviors such as “requesting drugs by name,
- 20 “demanding or manipulative behavior,” seeing more than one doctor
- 21 to obtain opioids, and hoarding, are all signs of pseudoaddiction.
- 22 Purdue also spent over \$100,000 to support distribution of the book.
- 23 ○ Purdue sponsored APF’s *A Policymaker’s Guide to Understanding*
- 24 *Pain & Its Management*, which states: “Pseudo-addiction describes
- 25 patient behaviors that may occur when pain is undertreated. . . .
- 26 Pseudo-addiction can be distinguished from true addiction in that this
- 27 behavior ceases when pain is effectively treated.”
- 28

- A *Policymaker’s Guide to Understanding Pain & Its Management* also taught that “Symptoms of physical dependence can often be ameliorated by gradually decreasing the dose of medication during discontinuation,” but did not disclose the significant hardships that often accompany cessation of use.
- Purdue sales representatives told prescribers that the effects of withdrawal from opioid use can be successfully managed.
- Purdue sales representatives told prescribers that the potential for withdrawal on Butrans was low due to Butrans’ low potency and its extended release mechanism.

- Janssen:
 - Janssen’s website, Let’s Talk Pain, stated from 2009 through 2011 that “pseudoaddiction . . . refers to patient behaviors that may occur when pain is under-treated” and “[p]seudoaddiction is different from true addiction because such behaviors can be resolved with effective pain management.”
 - A Janssen PowerPoint presentation used for training its sales representatives titled “*Selling Nucynta ER*” indicates that the “low incidence of withdrawal symptoms” is a “core message” for its sales force. This message is repeated in numerous Janssen training materials between 2009 and 2011. The studies supporting this claim did not describe withdrawal symptoms in patients taking Nucynta ER beyond 90 days or at high doses and would therefore not be representative of withdrawal symptoms in the chronic pain population. Patients on opioid therapy long-term and at high doses will have a harder time discontinuing the drugs and are more likely to experience withdrawal symptoms. In addition, in claiming a low rate

of withdrawal symptoms, Janssen relied upon a study that only began tracking withdrawal symptoms in patients two to four days after discontinuing opioid use, when Janssen knew or should have known that these symptoms peak earlier than that for most patients. Relying on data after that initial window painted a misleading picture of the likelihood and severity of withdrawal associated with chronic opioid therapy. Janssen also knew or should have known that the patients involved in the study were not on the drug long enough to develop rates of withdrawal symptoms comparable to rates of withdrawal suffered by patients who use opioids for chronic pain—the use for which Janssen promoted Nucynta ER.

- Janssen sales representatives told prescribers that patients on Janssen's drugs were less susceptible to withdrawal than those on other opioids.

- Cephalon:

- Cephalon sponsored FSMB's Responsible Opioid Prescribing (2007), which taught that behaviors such as "requesting drugs by name," "demanding or manipulative behavior," seeing more than one doctor to obtain opioids, and hoarding are all signs of pseudoaddiction. Cephalon also spent \$150,000 to purchase copies of the book in bulk and distributed it through its pain sales force to 10,000 prescribers and 5,000 pharmacists.

- Endo:

- Endo distributed copies of a book by KOL Dr. Lynn Webster entitled *Avoiding Opioid Abuse While Managing Pain* (2007). Endo's internal planning documents describe the purpose of distributing this book as to "[i]ncrease the breadth and depth of the Opana ER prescriber

base.” The book claims that when faced with signs of aberrant behavior, the doctor should regard it as pseudoaddiction and thus, increasing the dose in most cases . . . should be the clinician’s first response.”

- Endo spent \$246,620 to buy copies of FSMB’s *Responsible Opioid Prescribing* (2007), which was distributed by Endo’s sales force. This book asserted that behaviors such as “requesting drugs by name,” “demanding or manipulative behavior,” seeing more than one doctor to obtain opioids, and hoarding, are all signs of “pseudoaddiction.”
- A CME sponsored by Endo, titled *Persistent Pain in the Older Adult*, taught that withdrawal symptoms can be avoided entirely by tapering the dose by 10-20% per day for ten days.
- Endo misrepresented that “symptoms of withdrawal do not indicate addiction.”³⁵³
- “Endo also trained its sales representatives to distinguish addiction from ‘pseudoaddiction.’”³⁵⁴

533. The RICO Defendants misrepresented that opioids were safe for the long-term treatment of chronic, non-acute, and non-cancer pain:

- Purdue:

- “[W]e do not want to niche OxyContin just for cancer pain.”³⁵⁵

three tablet strengths were passed around. OxyContin will be indicated for the relief of pain with the convenience of q12h dosing. OxyContin’s primary market positioning will be for cancer pain and the secondary market will be for non-malignant pain (musculoskeletal, injury and trauma). It was reinforced that we do not want to niche OxyContin just for cancer pain. OxyContin will be positioned into Step 2 of the

³⁵³ In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc., Assurance No. 15-228, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15, at 7 (Mar. 1, 2016), https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf.

³⁵⁴ Id.

³⁵⁵ Ryan, *Description of Hell*, <http://documents.latimes.com/oxycontin-launch-1995/> (emphasis in the L.A. Times document).

- 1 ○ OxyContin was safe and non-addictive when using extended release
2 formulations, and appropriate for use in non-cancer patients.³⁵⁶
- 3 ○ OxyContin should be prescribed not merely for severe short-term
4 pain associated with surgery or cancer, but also for less acute, longer-
5 lasting pain like arthritis, back pain, sports injuries, fibromyalgia with
6 almost limitless treatment potential.³⁵⁷

7 • Janssen:

- 8 ○ Duragesic was “more useful in a broader range of conditions or
9 patients than has been demonstrated by substantial evidence.”³⁵⁸
- 10 ○ Duragesic was “not just for end stage cancer anymore” when the
11 FDA only approved Duragesic for “the management of chronic pain
12 in patients who require continuous opioid analgesia for pain that
13 cannot be managed by lesser means.”³⁵⁹
- 14 ○ Misrepresented that “Duragesic can be used for any type of pain
15 management” despite the fact that the FDA approved warning stated
16 that “BECAUSE SERIOUS OR LIFE-THREATENING
17 HYPOVENTILATION COULD OCCUR, DURAGESIC®
18 (FENTANYL TRANSDERMAL SYSTEM) IS

22 ³⁵⁶ Charles Ornstein & Tracy Weber, *American Pain Foundation Shuts Down as*
23 *Senators Launch Investigation of Prescription Narcotics*, ProPublica (May 8,
24 2012, 8:57 PM),
25 http://www.opb.org/news/article/america_pain_foundation_shuts_down_as_senators_launch_investigation_of_prescription_narcotics/ (hereinafter “Ornstein,
26 *American Pain Foundation*

27 ³⁵⁷ Patrick Keefe, *The Family that Built an Empire of Pain*, New Yorker (Oct. 30,
28 2017), <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>

27 ³⁵⁸ NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to
28 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

28 ³⁵⁹ *Id.*

1 CONTRAINDEDICATED: In the management of acute or post-
 2 operative pain, including use in outpatient surgeries”³⁶⁰

3 ○ Misrepresented “numerous claims for the efficacy and safety of
 4 Duragesic,” but failed to “present[] any risk information concerning
 5 the boxed warnings, contraindications, warnings, or side effects
 6 associated with Duragesic’s use . . . [and] . . . fail[ed] to address
 7 important risks and restrictions associated with Duragesic
 8 therapy.”³⁶¹

9 ○ Misrepresented “[d]emonstrated effectiveness in chronic back pain
 10 with additional patient benefits, . . . 86% of patients experienced
 11 overall benefit in a clinical study based on: pain control, disability in
 12 ADLs, quality of sleep.”³⁶²

13 ● Cephalon:

14 ○ “[P]romoting [Actiq] for non-cancer patients to use for such maladies
 15 as migraines, sickle-cell pain crises, injuries, and in anticipation of
 16 changing wound dressings or radiation therapy.”³⁶³

17 ○ “[P]romot[ing] Actiq for use in patients who were not yet opioid
 18 tolerant, and for whom it could have life-threatening results.”³⁶⁴

19 ○ In 2011, Cephalon wrote an article titled “2011 Special Report: An
 20 Integrated Risk Evaluation and Risk Mitigation Strategy for Fentanyl
 21 Buccal Tablet (FENTORA®) AND Oral Transmucosal Fentanyl
 22 Citrate (Actiq®), published in Pain Medicine News. Plaintiffs are

24 ³⁶⁰ *Id.*

25 ³⁶¹ *Id.*

26 ³⁶² *Id.* at 2-3.

27 ³⁶³ Press Release, U.S. Department of Justice, Pharmaceutical Company Cephalon
 28 To Pay \$425 Million For Off-Label Drug Marketing (Sept. 29, 2008),
<https://www.justice.gov/archive/usao/pae/News/2008/sep/cephalonrelease.pdf>.

³⁶⁴ *Id.*

informed and believe that Cephalon misrepresented that its drugs were “shown to be effective in treatment of [break through pain] associated with multiple causes of pain,” not just cancer.

534. The RICO Defendants also misrepresented that opioids were safer than non-opioid analgesics because there is no ceiling dose for opioid treatment.

- Purdue:
 - Purdue's In the Face of Pain website, along with initiatives of APF, promoted the notion that if a patient's doctor does not prescribe them what—in their view—is a sufficient dose of opioids, they should find another doctor who will. In so doing, Purdue exerted undue, unfair, and improper influence over prescribers who face pressure to accede to the resulting demands.
 - Purdue sponsored APF's *A Policymaker's Guide to Understanding Pain & Its Management*, which taught that dose escalations are “sometimes necessary,” even indefinitely high ones, which suggested that high dose opioids are safe and appropriate and did not disclose the risks from high dose opioids. This publication is still available online.
 - Purdue sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which taught patients that opioids have “no ceiling dose” and are therefore the most appropriate treatment for severe pain. The guide also claimed that some patients “need” a larger dose of the drug, regardless of the dose currently prescribed. This language fails to disclose heightened risks at elevated doses.
 - *Treatment Options*, also taught that opioids differ from NSAIDs in that they have “no ceiling dose” and are therefore the most appropriate treatment for severe pain. *Treatment Options* continued,

1 warning that risks of NSAIDs increase if “taken for more than a
2 period of months,” with no corresponding warning about opioids.
3 The publication attributed 10,000 to 20,000 deaths annually to
4 NSAID overdose.

- 5 o Purdue sponsored a CME issued by the American Medical
6 Association in 2003, 2007, 2010, and 2013. The CME, *Overview of*
7 *Management Options*, was edited by KOL Dr. Russell Portenoy,
8 among others, and taught that other drugs, but not opioids, are unsafe
9 at high doses. The 2013 version is still available for CME credit.
- 10 o *Overview of Management Options* also taught NSAIDs and other
11 drugs, but not opioids, are unsafe at high doses.
- 12 o Purdue sponsored APF’s *Exit Wounds* (2009), which omits warnings
13 of the risk of interactions between opioids and benzodiazepines,
14 which would increase fatality risk. *Exit Wounds* also contained a
15 lengthy discussion of the dangers of using alcohol to treat chronic
16 pain but did not disclose dangers of mixing
- 17 o Purdue sales representatives told prescribers that opioids were just as
18 effective for treating patients long-term and omitted any discussion
19 that increased tolerance would require increasing, and increasingly
20 dangerous, doses.
- 21 o Purdue sales representatives told prescribers that NSAIDs were more
22 toxic than opioids.

23 • Janssen:

- 24 o Janssen sponsored a patient education guide entitled *Finding Relief:*
25 *Pain Management for Older Adults* (2009), which its personnel
26 reviewed and approved and its sales force distributed. This guide
27 listed dose limitations as “disadvantages” of other pain medicines but

omitted any discussion of risks of increased doses from opioids. The publication also falsely claimed that it is a “myth” that “opioid doses have to be bigger over time.”

- *Finding Relief: Pain Management for Older Adults* also described the advantages and disadvantages of NSAIDs on one page, and the “myths/facts” of opioids on the facing page. The disadvantages of NSAIDs are described as involving “stomach upset or bleeding,” “kidney or liver damage if taken at high doses or for a long time,” “adverse reactions in people with asthma,” and “can increase the risk of heart attack and stroke.” The only adverse effects of opioids listed are “upset stomach or sleepiness,” which the brochure claims will go away, and constipation.
- Janssen sponsored APF’s *Exit Wounds* (2009), which omits warnings of the risk of interactions between opioids and benzodiazepines. Janssen’s label for Duragesic, however, states that use with benzodiazepines “may cause respiratory depression, [low blood pressure], and profound sedation or potentially result in coma. Exit Wounds also contained a lengthy discussion of the dangers of using alcohol to treat chronic pain but did not disclose dangers of mixing alcohol and opioids.
- Janssen sales representatives told prescribers that Nucynta was not an opioid, making it a good choice for chronic pain patients who previously were unable to continue opioid therapy due to excessive side effects. This statement was misleading because Nucynta is an opioid and has the same effects as other opioids.

- Cephalon:

- Cephalon sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which claims that some patients "need" a larger dose of their opioid, regardless of the dose currently prescribed.
- *Treatment Options*, also taught patients that opioids differ from NSAIDs in that they have "no ceiling dose" and are therefore the most appropriate treatment for severe pain. *Treatment Options* continued, warning that risks of NSAIDs increase if "taken more than a period of months." With no corresponding warning about opioids. The publication attributed 10,000 to 20,000 deaths annually to NSAID overdose.
- Cephalon sponsored a CME written by KOL Dr. Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, which was offered online by Medscape, LLC from September 28, 2007 through December 15, 2008. The CME taught that non-opioid analgesics and combination opioids that include aspirin and acetaminophen are less effective to treat breakthrough pain because of dose limitations.
- Cephalon sales representatives assured prescribers that opioids were safe, even at high doses.
- Cephalon sales representatives told prescribers that NSAIDs were more toxic than opioids.
- "[P]romot[ing] Actiq for use in patients who were not yet opioid tolerant, and for whom it could have life-threatening results."³⁶⁵

- Endo:

- Endo sponsored a website, painknowledge.com, through APF and NIPC, which claimed in 2009 that opioids may be increased until

³⁶⁵ *Id.*

1 “you are on the right dose of medication for your pain,” and once that
2 occurs, further dose increases would not occur. Endo funded the site,
3 which was a part of Endo’s marketing plan, and tracked visitors to it.
4 ○ Through painknowledge.com Endo distributed a flyer called “Pain:
5 Opioid Therapy.” This publication included a list of adverse effects
6 from opioids that omitted significant adverse effects like
7 hyperalgesia, immune and hormone dysfunction, cognitive
8 impairment, tolerance, dependence, addiction, and death. Endo
9 continued to provide funding for this website through 2012, and
10 closely tracked unique visitors to it.
11 ○ Endo provided grants to APF to distribute Exit Wounds (2009),
12 which omitted warnings of the risk of interactions between opioids
13 and benzodiazepines, which would increase fatality risk. Exit
14 Wounds also contained a lengthy discussion of the dangers of using
15 alcohol to treat chronic pain but did not disclose dangers of mixing
16 alcohol and opioids.
17 ○ Endo sales representatives told prescribers that NSAIDs were more
18 toxic than opioids.
19 ○ Endo distributed a patient education pamphlet edited by KOL Dr.
20 Russell Portenoy titled *Understanding Your Pain: Taking Oral*
21 *Opioid Analgesics*. In Q&A format, it asked: “If I take the opioid
22 now, will it work later when I really need it?” The response was:
23 “The dose can be increased . . . You won’t ‘run out’ of pain relief.”
24 ○ Endo distributed a “case study” to prescribers titled *Case Challenges*
25 *in Pain Management: Opioid Therapy for Chronic Pain*. The study
26 cites an example, meant to be representative, of a patient “with a
27 massive upper gastrointestinal bleed believed to be related to his
28

1 protracted use of NSAIDs” (over eight years), and recommends
 2 treating with opioids instead.

3 535. These misrepresentations, and the legion of other representations
 4 made by the RICO Defendants and members of Opioid Marketing Enterprise all
 5 furthered the common purpose and fraudulent scheme of the Opioid Marketing
 6 Enterprise. But they were demonstrably false, as confirmed by investigations and
 7 enforcement actions against the RICO Marketing Defendants.

8 536. In May 2007, Purdue and three of its executives pled guilty to federal
 9 charges of misbranding OxyContin in what the company acknowledged was an
 10 attempt to mislead doctors about the risk of addiction. Purdue was ordered to pay
 11 \$600 million in fines and fees. In its plea, Purdue admitted that its promotion of
 12 OxyContin was misleading and inaccurate, misrepresented the risk of addiction
 13 and was unsupported by science. The Order adopting the guilty pleas provide:

14
 15 effects than immediate-release opioids resulting in less
 16 euphoria and less potential for abuse than short-acting
 opioids;

- 17 d. Told certain health care providers that patients could stop
 therapy abruptly without experiencing withdrawal
 symptoms and that patients who took OxyContin would not
 develop tolerance to the drug; and
- 18 e. Told certain health care providers that OxyContin did not
 cause a “buzz” or euphoria, caused less euphoria, had less
 addiction potential, had less abuse potential, was less likely
 to be diverted than immediate-release opioids, and could be
 used to “weed out” addicts and drug seekers.

23 (Information ¶ 19.) Purdue has agreed that these facts are true, and the individual
 24 defendants, while they do not agree that they had knowledge of these things, have
 25 agreed that the court may accept these facts in support of their guilty pleas. (Agreed
 26 Statement of Facts ¶ 46.)

27 537. Additionally, Michael Friedman (“Friedman”), the company’s
 28 president, pled guilty to a misbranding charge and agreed to pay \$19 million in

1 fines; Howard R. Udell (“Udell”), Purdue’s top lawyer, also pled guilty and
 2 agreed to pay \$8 million in fines; and Paul D. Goldenheim (“Goldenheim”), its
 3 former medical director, pled guilty as well and agreed to pay \$7.5 million in
 4 fines.³⁶⁶

5 538. In a statement announcing the guilty plea, John Brownlee
 6 (“Brownlee”), the U.S. Attorney for the Western District of Virginia, stated:

7 Purdue claimed it had created the miracle drug – a low risk drug that
 8 could provide long acting pain relief but was less addictive and less
 9 subject to abuse. Purdue’s marketing campaign worked, and sales for
 OxyContin skyrocketed – making billions for Purdue and millions for
 its top executives.

10 But OxyContin offered no miracles to those suffering in pain. Purdue’s claims that OxyContin was less addictive and less subject to abuse and diversion were false – and Purdue knew its claims were false. The result of their misrepresentations and crimes sparked one of our nation’s greatest prescription drug failures. . . . OxyContin was the child of marketers and bottom line financial decision making.³⁶⁷

11 539. Brownlee characterized Purdue’s criminal activity as follows:

12 First, Purdue trained its sales representatives to falsely inform
 13 health care providers that it was more difficult to extract the
 14 oxycodone from an OxyContin tablet for the purpose of intravenous
 15 abuse. Purdue ordered this training even though its own study showed
 16 that a drug abuser could extract approximately 68% of the oxycodone
 17 from a single 10 mg OxyContin tablet by simply crushing the tablet,
 18 stirring it in water, and drawing the solution through cotton into a
 syringe.

19 Second, Purdue falsely instructed its sales representatives to
 20 inform health care providers that OxyContin could create fewer
 21 chances for addiction than immediate-release opioids.

22 Third, Purdue sponsored training that falsely taught Purdue
 23 sales supervisors that OxyContin had fewer “peak and trough” blood
 24 level effects than immediate-release opioids resulting in less euphoria
 25 and less potential for abuse than short-acting opioids.

26 Fourth, Purdue falsely told certain health care providers that
 27 patients could stop therapy abruptly without experiencing withdrawal

28³⁶⁶ *Id.*

³⁶⁷ Press Release, U.S. Attorney for the Western District of Virginia, Statement of United States Attorney John Brownlee on the Guilty Plea of the Purdue Frederick Company and Its Executives for Illegally Misbranding OxyContin (May 10, 2007), <https://assets.documentcloud.org/documents/279028/purdue-guilty-plea.pdf>.

symptoms and that patients who took OxyContin would not develop tolerance to the drug.

And fifth, Purdue falsely told health care providers that OxyContin did not cause a “buzz” or euphoria, caused less euphoria, had less addiction potential, had less abuse potential, was less likely to be diverted than immediate-release opioids, and could be used to “weed out” addicts and drug seekers.³⁶⁸

540. Purdue pled guilty to illegally misbranding OxyContin in an effort to mislead and defraud physicians and consumers, while Friedman, Udell and Goldenheim pled guilty to the misdemeanor charge of misbranding OxyContin for introducing misbranded drugs into interstate commerce in violation of 21 U.S.C. §§ 331(a), 333(a)(1)-(2) and 352(a).

541. Similarly, Endo's marketing of Purdue was criticized and punished by the FDA and New York Attorney General.

542. On February 18, 2017, the State of New York announced a settlement with Endo requiring it “to cease all misrepresentations regarding the properties of Opana ER [and] to describe accurately the risk of addiction to Opana ER.”³⁶⁹ In the Assurance of Discontinuance that effectuated the settlement, the State of New York stated that Endo knew about the risks arising from the reformulated Opana ER even before it received FDA approval. Among other things, the investigation concluded that:

- Endo improperly marketed Opana ER as designed to be crush resistant, when Endo's own studies dating from 2009 and 2010 showed that the pill could be crushed and ground;

368 *Id.*

³⁶⁹ Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman Announces Settlement With Endo Health Solutions Inc. & Endo Pharmaceuticals Inc. Over Marketing Of Prescription Opioid Drugs (Mar. 3, 2016), <https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-endo-health-solutions-inc-endo-pharmaceuticals> (last accessed on March 9, 2018).

- 1 • Endo improperly instructed its sales representatives to diminish and distort
- 2 the risks associated with Opana ER, including the serious danger of
- 3 addiction; and
- 4 • Endo made unsupported claims comparing Opana ER to other opioids and
- 5 failed to disclose accurate information regarding studies addressing the
- 6 negative effects of Opana ER.³⁷⁰

7 543. The 2017 settlement also identified and discussed a February 2013
 8 communication from a consultant hired by Endo to the company, in which the
 9 consultant concluded that “[t]he initial data presented do not necessarily establish
 10 that the reformulated Opana ER is tamper resistant.” The same consultant also
 11 reported that the distribution of the reformulated Opana ER had already led to
 12 higher levels of abuse of the drug via injection.³⁷¹

13 544. The Office of the Attorney General of New York also revealed that
 14 the “managed care dossier” Endo provided to formulary committees of healthcare
 15 plans and pharmacy benefit managers misrepresented the studies that had been
 16 conducted on Opana ER. According to Endo’s vice president for
 17 pharmacovigilance and risk management, the dossier was presented as a complete
 18 compendium of all research on the drug. However, it omitted certain studies:
 19 Study 108 (completed in 2009) and Study 109 (completed in 2010), which showed
 20 that reformulated Opana ER could be ground and chewed.

21 545. The settlement also detailed Endo’s false and misleading
 22 representations about the non-addictiveness of opioids and Opana. For example,
 23 until April 2012, Endo’s website for the drug, www.opana.com, contained the
 24 following representation: “Most healthcare providers who treat patients with pain
 25 agree that patients treated with prolonged opioid medicines usually do not become

26
 27
 28 ³⁷⁰ *Id.*

³⁷¹ *Id.* at 6.

1 addicted.”³⁷² However, Endo neither conducted nor possessed a survey
2 demonstrating that most healthcare providers who treat patients with pain agree
3 with that representation.

4 546. The Office of the Attorney General of New York also disclosed the
5 following facts that it determined to violate Opana’s obligations to truthfully
6 market its products:

7 a. Training materials provided by Endo to sales
8 representatives stated: “‘Symptoms of withdrawal do not
9 indicate addiction.’”³⁷³ This representation is inconsistent with
10 the diagnosis of opioid-use disorder as provided in the
11 Diagnostic and Statistical Manual of Mental Disorders by the
12 American Psychiatric Association (Fifth Edition).

13 b. Endo trained its sales representatives to falsely
14 distinguish addiction from “pseudoaddiction,” which it defined
15 as a condition in which patients exhibit drug-seeking behavior
16 that resembles but is not the same as addiction. Endo’s vice
17 president for pharmacovigilance and risk management testified
18 that he was not aware of any research validating the concept of
19 pseudoaddiction.

20 547. On June 9, 2017, the FDA asked Endo to voluntarily cease sales of
21 Opana ER after determining that the risks associated with its abuse outweighed
22 the benefits. According to Dr. Janet Woodcock, director of the FDA’s Center for
23 Drug Evaluation and Research, the risks include “several serious problems,”
24 including “outbreaks of HIV and Hepatitis C from sharing the drug after it was

25
26
27
28

³⁷² *Id.*

³⁷³ *Id.* at 7.

1 extracted by abusers” and ““a serious disease outbreak.”³⁷⁴ If Endo did not
 2 comply, the FDA stated that it “intends to take steps to formally require its
 3 removal by withdrawing approval.”³⁷⁵

4 548. Like Purdue and Endo, Janssen was the subject of an FDA
 5 enforcement action that identified its marketing statements as misrepresentations.
 6 For example:

7 549. On February 15, 2000, the FDA sent Janssen a letter concerning the
 8 alleged dissemination of “homemade” promotional pieces that promoted
 9 Duragesic in violation of the Federal Food, Drug, and Cosmetic Act. In a
 10 subsequent letter, dated March 30, 2000, the FDA explained that the “homemade”
 11 promotional pieces were “false or misleading because they contain
 12 misrepresentations of safety information, broaden Duragesic’s indication, contain
 13 unsubstantiated claims, and lack fair balance.”³⁷⁶

14 550. The March 30, 2000 letter identified specific violations, including
 15 misrepresentations that Duragesic had a low potential for abuse:

16 You present the claim, “Low abuse potential!” This claim suggests
 17 that Duragesic has less potential for abuse than other currently
 18 available opioids. However, this claim has not been demonstrated by
 19 substantial evidence. Furthermore, this claim is contradictory to
 20 information in the approved product labeling (PI) that states,
 21 “Fentanyl is a Schedule II controlled substance and can produce drug
 22 dependence similar to that produced by morphine.” Therefore, this
 23 claim is false or misleading.³⁷⁷

24 551. The March 30, 2000 letter also stated that the promotional materials
 25 represented that Duragesic was “more useful in a broader range of conditions or
 26
 27
 28

³⁷⁴ *FDA requests removal of Opana ER for risks related to abuse*, June 8, 2017,
<https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm562401.htm>.

³⁷⁵ *Id.*

³⁷⁶ NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to
 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

³⁷⁷ *Id.*

1 patients than has been demonstrated by substantial evidence.”³⁷⁸ Specifically, the
2 FDA stated that Janssen was marketing Duragesic for indications other than the
3 treatment of chronic pain that cannot otherwise be managed, for which it was
4 approved:

5 You present the claim, “It’s not just for end stage cancer anymore!”
6 This claim suggests that Duragesic can be used for any type of pain
7 management. However, the PI for Duragesic states, “Duragesic
8 (fentanyl transdermal system) is indicated in the management of
9 chronic pain in patients who require continuous opioid analgesia for
10 pain that cannot be managed by lesser means . . .” Therefore, the
11 suggestion that Duragesic can be used for any type of pain
12 management promotes Duragesic[] for a much broader use than is
13 recommended in the PI, and thus, is misleading. In addition, the
14 suggestion that Duragesic can be used to treat any kind of pain is
15 contradictory to the boxed warning in the PI. Specifically, the PI
16 states,

17 BECAUSE SERIOUS OR LIFE-THREATENING
18 HYPOVENTILATION COULD OCCUR, DURAGESIC®
19 (FENTANYL TRANSDERMAL SYSTEM) IS
20 CONTRAINDICATED:

21 In the management of acute or post-operative pain, including use in
22 outpatient surgeries . . .³⁷⁹

23 552. The March 30, 2000 letter also stated Janssen failed to adequately
24 present “contraindications, warnings, precautions, and side effects with a
25 prominence and readability reasonably comparable to the presentation of
26 information relating to the effectiveness of the product.”³⁸⁰

27 553. On February 15, 2000, the FDA sent Janssen a letter concerning the
28 alleged dissemination of “homemade” promotional pieces that promoted
Duragesic in violation of the Federal Food, Drug, and Cosmetic Act. In a
subsequent letter, dated March 30, 2000, the FDA explained that the “homemade”
promotional pieces were “false or misleading because they contain

27 ³⁷⁸ *Id.*

28 ³⁷⁹ *Id.* at 2-3.

³⁸⁰ *Id.* at 3 (emphasis in original).

1 misrepresentations of safety information, broaden Duragesic's indication, contain
2 unsubstantiated claims, and lack fair balance.”³⁸¹

3 554. The March 30, 2000 letter identified specific violations, including
4 misrepresentations that Duragesic had a low potential for abuse:

5 You present the claim, “Low abuse potential!” This claim suggests
6 that Duragesic has less potential for abuse than other currently
7 available opioids. However, this claim has not been demonstrated by
8 substantial evidence. Furthermore, this claim is contradictory to
9 information in the approved product labeling (PI) that states,
“Fentanyl is a Schedule II controlled substance and can produce drug
dependence similar to that produced by morphine.” Therefore, this
claim is false or misleading.³⁸²

10 555. The March 30, 2000 letter also stated that the promotional materials
11 represented that Duragesic was “more useful in a broader range of conditions or
12 patients than has been demonstrated by substantial evidence.”³⁸³ Specifically, the
13 FDA stated that Janssen was marketing Duragesic for indications other than the
14 treatment of chronic pain that cannot otherwise be managed, for which it was
15 approved:

16 You present the claim, “It’s not just for end stage cancer anymore!”
17 This claim suggests that Duragesic can be used for any type of pain
18 management. However, the PI for Duragesic states, “Duragesic
19 (fentanyl transdermal system) is indicated in the management of
20 chronic pain in patients who require continuous opioid analgesia for
21 pain that cannot be managed by lesser means . . .” Therefore, the
22 suggestion that Duragesic can be used for any type of pain
23 management promotes Duragesic[] for a much broader use than is
24 recommended in the PI, and thus, is misleading. In addition, the
25 suggestion that Duragesic can be used to treat any kind of pain is
26 contradictory to the boxed warning in the PI. Specifically, the PI
states,

27 BECAUSE SERIOUS OR LIFE-THREATENING
28 HYPOVENTILATION COULD OCCUR, DURAGESIC®
(FENTANYL TRANSDERMAL SYSTEM) IS
CONTRAINdICATED:

26 ³⁸¹ NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to
27 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

28 ³⁸² *Id.*

³⁸³ *Id.*

1 In the management of acute or post-operative pain, including use in
2 outpatient surgeries . . .³⁸⁴

3 556. The March 30, 2000 letter also stated Janssen failed to adequately
4 present “contraindications, warnings, precautions, and side effects with a
5 prominence and readability reasonably comparable to the presentation of
6 information relating to the effectiveness of the product”:

7 Although this piece contains numerous claims for the efficacy and
8 safety of Duragesic, you have not presented any risk information
9 concerning the boxed warnings, contraindications, warnings,
10 precautions, or side effects associated with Duragesic’s use . . .
11 Therefore, this promotional piece is lacking in fair balance, or
12 otherwise misleading, because it fails to address important risks and
13 restrictions associated with Duragesic therapy.³⁸⁵

14 557. On September 2, 2004, the U.S. Department of Health and Human
15 Services (“HHS”) sent Janssen a warning letter concerning Duragesic due to
16 “false or misleading claims about the abuse potential and other risks of the drug,
17 and . . . unsubstantiated effectiveness claims for Duragesic,” including,
18 specifically, “suggesting that Duragesic has a lower potential for abuse compared
19 to other opioid products.”

20 558. The September 2, 2004 letter warned Janssen regarding its claims
21 that Duragesic had a low reported rate of mentions in the Drug Abuse Warning
22 Network (“DAWN”) as compared to other opioids. The letter stated that the claim
23 was false or misleading because the claim was not based on substantial data and
24 because the lower rate of mentions was likely attributable to Duragesic’s lower
25 frequency of use compared to other opioids listed in DAWN:

26 The file card presents the prominent claim, “Low reported rate
27 of mentions in DAWN data,” along with Drug Abuse Warning
28 Network (DAWN) data comparing the number of mentions for
29 Fentanyl/combinations (710 mentions) to other listed opioid products,
30 including Hydrocodone/combinations (21,567 mentions),
31 Oxycodone/combinations (18,409 mentions), and Methadone (10,725
32 mentions). The file card thus suggests that Duragesic is less abused
33 than other opioid drugs.

384 *Id.* at 2-3.

385 *Id.* at 3 (emphasis in original).

1 This is false or misleading for two reasons. First, we are not
 2 aware of substantial evidence or substantial clinical experience to
 3 support this comparative claim. The DAWN data cannot provide the
 4 basis for a valid comparison among these products. As you know,
 5 DAWN is not a clinical trial database. Instead, it is a national public
 6 health surveillance system that monitors drug-related emergency
 7 department visits and deaths. If you have other data demonstrating
 8 that Duragesic is less abused, please submit them.

9 Second, Duragesic is not as widely prescribed as other opioid
 10 products. As a result, the relatively lower number of mentions could
 11 be attributed to the lower frequency of use, and not to a lower
 12 incidence of abuse. The file card fails to disclose this information.³⁸⁶

13 559. The September 2, 2004 letter also detailed a series of unsubstantiated
 14 false or misleading claims regarding Duragesic's effectiveness. The letter
 15 concluded that various claims made by Janssen were insufficiently supported,
 16 including:

- 17 • “Demonstrated effectiveness in chronic back pain with additional patient
 18 benefits, . . . 86% of patients experienced overall benefit in a clinical study
 19 based on: pain control, disability in ADLs, quality of sleep.””
- 20 • “All patients who experienced overall benefit from DURAGESIC would
 21 recommend it to others with chronic low back pain.””
- 22 • “Significantly reduced nighttime awakenings.””
- 23 • “Significant improvement in disability scores as measured by the Oswestry
 24 Disability Questionnaire and Pain Disability Index.””
- 25 • “Significant improvement in physical functioning summary score.””
- 26 • “Significant improvement in social functioning.””³⁸⁷

27 560. In addition, the September 2, 2004 letter identified “outcome claims
 28 [that] are misleading because they imply that patients will experience improved
 29 social or physical functioning or improved work productivity when using

26 ³⁸⁶ Warning Letter from Thomas W. Abrams, U.S. Department of Health and
 27 Human Services, to Ajit Shetty, Janssen Pharmaceutica, Inc. (Sept. 2, 2004),
 28 https://www.pharmamedtechbi.com/~media/Images/Publications/Archive/The%20Pink%20Sheet/66/038/00660380018/040920_duragesic_letter.pdf at 2.

387 *Id.* at 2-3.

1 Duragesic.” The claims include ““1,360 loaves . . . and counting,’ ‘[w]ork,
 2 uninterrupted,’ ‘[l]ife, uninterrupted,’ ‘[g]ame, uninterrupted,’ ‘[c]hronic pain
 3 relief that supports functionality,’ ‘[h]elps patients think less about their pain,’ and
 4 ‘[i]mprove[s] . . . physical and social functioning.”’ The September 2, 2004 letter
 5 stated: “Janssen has not provided references to support these outcome claims. We
 6 are not aware of substantial evidence or substantial clinical experience to support
 7 these claims.”³⁸⁸

8 561. On July 15, 2005, the FDA issued a public health advisory warning
 9 doctors of deaths resulting from the use of Duragesic and its generic competitor,
 10 manufactured by Mylan N.V. Plaintiffs are informed and believe that the advisory
 11 noted that the FDA had been ““examining the circumstances of product use to
 12 determine if the reported adverse events may be related to inappropriate use of the
 13 patch”” and noted the possibility “that patients and physicians might be unaware
 14 of the risks” of using the fentanyl transdermal patch, which is a potent opioid
 15 analgesic meant to treat chronic pain that does not respond to other painkillers.³⁸⁹

16 562. Finally, Cephalon has been the subject of investigations and
 17 enforcement actions for its misrepresentations concerning Actiq. For example:

18 563. In October 2000, Cephalon acquired the worldwide product rights to
 19 Actiq and began marketing and selling Actiq in the United States. The FDA
 20 explicitly stated that Actiq “***must not*** be used in opioid non-tolerant patients,” was
 21 contraindicated for the management of acute or postoperative pain, could be
 22 deadly to children, and was “intended to be used only in the care of opioid-
 23 tolerant cancer patients and only by oncologists and pain specialists who are
 24 knowledgeable of and skilled in the use of Schedule II opioids to treat cancer

25
 26
 27
 28 ³⁸⁸ *Id.* at 3.

³⁸⁹ *New Fentanyl Warnings: More Needed to Protect Patients*, Institute for Safe
 Medication Practices, August 11, 2005,
<https://www.ismp.org/newsletters/acutecare/articles/20050811.asp>

1 pain.”³⁹⁰ The FDA also required that Actiq be provided only in compliance with a
 2 strict risk management program that explicitly limited the drug’s direct marketing
 3 to the approved target audiences, defined as oncologists, pain specialists, their
 4 nurses and office staff.³⁹¹

5 564. Cephalon purchased the rights to Fentora, an even faster-acting tablet
 6 formulation of fentanyl, from Cima Labs, and submitted a new drug application to
 7 the FDA in August 2005. In September 2006, Cephalon received FDA approval to
 8 sell this faster-acting version of Actiq; but once again, concerned about the power
 9 and risks inherent to fentanyl, the FDA limited Fentora’s approval to the treatment
 10 of BTP in cancer patients who were already tolerant to around-the-clock opioid
 11 therapy for their underlying persistent cancer pain. Cephalon began marketing and
 12 selling Fentora in October 2006.

13 565. Due to the FDA’s restrictions, Actiq’s consumer base was limited, as
 14 was its potential for growing revenue. In order to increase its revenue and market
 15 share, Cephalon needed to find a broader audience and thus began marketing its
 16 lollipop to treat headaches, back pain, sports injuries and other chronic non-cancer
 17 pain, targeting non-oncology practices, including, but not limited to, pain doctors,
 18 general practitioners, migraine clinics, anesthesiologists and sports clinics. It did
 19 so in violation of applicable regulations prohibiting the marketing of medications
 20 for off-label use and indirect contravention of the FDA’s strict instructions that
 21 Actiq be prescribed only to terminal cancer patients and by oncologists and pain
 22 management doctors experienced in treating cancer pain.

23 566. Beginning in or about 2003, former Cephalon employees filed four
 24 whistleblower lawsuits claiming the company had wrongfully marketed Actiq for
 25
 26

27 ³⁹⁰ *Id.*
 28 ³⁹¹ See John Carreyrou, *Narcotic “Lollipop” Becomes Big Seller Despite FDA Curbs*, Wall St. J. (Nov. 3, 2006), <https://www.opiates.com/media/narcotic-lollipop-becomes-big-seller-despite-fdacurbs/>.

1 unapproved off-label uses. On September 29, 2008, Cephalon finalized and
 2 entered into a corporate integrity agreement with the Office of the Inspector
 3 General of HHS and agreed to pay \$425 million in civil and criminal penalties for
 4 its off-label marketing of Actiq and two other drugs (Gabitril and Provigil).

5 According to a DOJ press release, Cephalon trained sales representatives to
 6 disregard restrictions of the FDA-approved label, employed sales representatives
 7 and healthcare professionals to speak to physicians about off-label uses of the
 8 three drugs and funded CME to promote off-label uses. Specifically, the DOJ
 9 stated:

10 From 2001 through at least 2006, Cephalon was allegedly promoting
 11 [Actiq] for non-cancer patients to use for such maladies as migraines,
 12 sickle-cell pain crises, injuries, and in anticipation of changing wound
 13 dressings or radiation therapy. Cephalon also promoted Actiq for use
 14 in patients who were not yet opioid-tolerant, and for whom it could
 15 have life-threatening results.³⁹²

16 567. Then-acting U.S. Attorney Laurie Magid commented on the dangers
 17 of Cephalon's unlawful practices:

18 “This company subverted the very process put in place to protect the public
 19 from harm, and put patients' health at risk for nothing more than boosting
 20 its bottom line. People have an absolute right to their doctors' best medical
 21 judgment. They need to know the recommendations a doctor makes are not
 22 influenced by sales tactics designed to convince the doctor that the drug
 23 being prescribed is safe for uses beyond what the FDA has approved.”³⁹³

24 568. Upon information and belief, documents uncovered in the
 25 government's investigations confirm that Cephalon directly targeted non-
 26 oncology practices and pushed its sales representatives to market Actiq for off-
 27 label use. For instance, the government's investigations confirmed:
 28

29 ³⁹² Press Release, U.S. Department of Justice, Pharmaceutical Company Cephalon
 30 To Pay \$425 Million For Off-Label Drug Marketing (Sept. 29, 2008),
 31 <https://www.justice.gov/archive/usao/pae/News/2008/sep/cephalonrelease.pdf>.

32 ³⁹³ *Id.*

- 1 a. Cephalon instructed its sales representatives to ask non-cancer doctors
2 whether they have the potential to treat cancer pain. Even if the doctor
3 answered “no,” a decision tree provided by Cephalon instructed the sales
4 representatives to give these physicians free Actiq coupons;
- 5 b. Cephalon targeted neurologists in order to encourage them to prescribe
6 Actiq to patients with migraine headaches;
- 7 c. Cephalon sales representatives utilized the assistance of outside pain
8 management specialists when visiting non-cancer physicians to pitch Actiq. The
9 pain management specialist would falsely inform the physician that Actiq does not
10 cause patients to experience a “high” and carries a low risk of diversion toward
11 recreational use;
- 12 d. Cephalon set sales quotas for its sales and marketing representatives that
13 could not possibly have been met solely by promoting Actiq for its FDA-approved
14 indication;
- 15 e. Cephalon promoted the use of higher doses of Actiq than patients required
16 by encouraging prescriptions of the drug to include larger-than-necessary numbers
17 of lozenges with unnecessarily high doses of fentanyl; and
- 18 f. Cephalon promoted Actiq for off-label use by funding and controlling
19 CME seminars that promoted and misrepresented the efficacy of the
20 drug for off-label uses such as treating migraine headaches and for
21 patients not already opioid-tolerant.³⁹⁴

22 569. The FDA’s letters and safety alerts, the DOJ and state investigations,
23 and the massive settlement seemed to have had little impact on Cephalon as it
24 continued its deceptive marketing strategy for both Actiq and Fentora.

25
26
27

³⁹⁴ John Carreyrou, Cephalon Used Improper Tactics to Sell Drug, Probe Finds,
28 Wall St. J., Nov. 21, 2006, at B1 (hereinafter “Carreyrou, Cephalon Used Improper
Tactics”).

1 570. On September 27, 2007, the FDA issued a public health advisory to
 2 address numerous reports that patients who did not have cancer or were not
 3 opioid-tolerant had been prescribed Fentora, and death or life-threatening side
 4 effects had resulted. The FDA warned: “Fentora should not be used to treat any
 5 type of short-term pain.”³⁹⁵

6 571. Nevertheless, in 2008, Cephalon pushed forward to expand the target
 7 base for Fentora and filed a supplemental drug application requesting FDA
 8 approval of Fentora for the treatment of non-cancer BTP. In the application and
 9 supporting presentations to the FDA, Cephalon admitted both that it knew the
 10 drug was heavily prescribed for off-label use and that the drug’s safety for such
 11 use had never been clinically evaluated.³⁹⁶ An FDA advisory committee noted that
 12 Fentora’s existing risk management program was ineffective and stated that
 13 Cephalon would have to institute a risk evaluation and mitigation strategy for the
 14 drug before the FDA would consider broader label indications. In response,
 15 Cephalon revised Fentora’s label and medication guide to add strengthened
 16 warnings.

17 572. But in 2009, the FDA once again informed Cephalon that the risk
 18 management program was not sufficient to ensure the safe use of Fentora for
 19 already approved indications.

20 573. On March 26, 2009, the FDA warned Cephalon against its
 21 misleading advertising of Fentora (“Warning Letter”). The Warning Letter
 22

23 395 Press Release, U.S. Food & Drug Administration, Public Health Advisory:
 24 Important Information for the Safe Use of Fentora (fentanyl buccal tablets) (Sept.
 25 26, 2007), <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm051273.htm>.

26 396 FENTORA (fentanyl buccal tablet) CII, Joint Meeting of Anesthetic and Life
 27 Support Drugs and
 28 Drug Safety and Risk Management Advisory Committee, U.S. Food & Drug
 Administration (May 6, 2008), <https://www.fda.gov/ohrms/dockets/ac/08/slides/2008-4356s2-03-Cephalon.pdf>.

1 described a Fentora Internet advertisement as misleading because it purported to
 2 broaden “the indication for Fentora by implying that any patient with cancer who
 3 requires treatment for breakthrough pain is a candidate for Fentora . . . when this
 4 is not the case.”³⁹⁷ Rather, Fentora was only indicated for those who were already
 5 opioid tolerant. It further criticized Cephalon’s other direct Fentora advertisements
 6 because they did not disclose the risks associated with the drug.

7 574. Flagrantly disregarding the FDA’s refusal to approve Fentora for
 8 non-cancer BTP and its warning against marketing the drug for the same,
 9 Cephalon continued to use the same sales tactics to push Fentora as it did with
 10 Actiq.

11 575. The misrepresentations disseminated by members of the Opioid
 12 Marketing Enterprise, and the RICO Marketing Defendants, caused The County
 13 and California consumers to pay for excessive opioid prescriptions, suffer injuries
 14 and losses, and to incur costs associated with the opioid epidemic caused by the
 15 Opioid Marketing Enterprise.

16 576. The RICO Marketing Defendants alone could not have accomplished
 17 the purpose of the Opioid Marketing Enterprise without the assistance of the Front
 18 Groups and KOLs, who were perceived as “neutral” and more “scientific” than
 19 the RICO Defendants themselves. Without these misrepresentations, the Opioid
 20 Marketing Enterprise could not have achieved its common purpose.

21 577. The impact of the Opioid Marketing Enterprise’s scheme is still in
 22 place – i.e., the opioids continue to be prescribed and used for chronic pain
 23 throughout the State of California, and the epidemic continues to injure The
 24 County, and consume the resources of The County’s and California’s health care
 25 and law enforcement systems.

26
 27 ³⁹⁷ Letter from Michael Sauers, Regulatory Review Officer, Division of Drug
 28 Marketing, Advertising and Communications, to Carole S. Marchione, Senior
 Director and Group Leader, Regulatory Affairs (March 26, 2009)

1 578. The foregoing evidences that the RICO Marketing Defendants, the
2 Front Groups, and the KOLs were each willing participants in the Opioid
3 Marketing Enterprise, had a common purpose and interest in the object of the
4 scheme, and functioned within a structure designed to effectuate the Enterprise's
5 purpose.

6 **B. CONDUCT OF THE OPIOID MARKETING ENTERPRISE.**

7 579. During time period described in this Complaint, from approximately
8 the late 1990s to the present, the RICO Marketing Defendants exerted control over
9 the Opioid Marketing Enterprise and participated in the operation or management
10 of the affairs of the Opioid Marketing Enterprise, directly or indirectly, in the
11 following ways:

- 12 a. Creating a body of deceptive, misleading and unsupported medical and
13 popular literature about opioids that (a) understated the risks and
14 overstated the benefits of long-term use; (b) appeared to be the result of
15 independent, objective research; and (c) was thus more likely to be
16 relied upon by physicians, patients, and payors;
- 17 b. Creating a body of deceptive, misleading and unsupported electronic and
18 print advertisements about opioids that (a) understated the risks and
19 overstated the benefits of long-term use; (b) appeared to be the result of
20 independent, objective research; and (c) was thus more likely to be
21 relied upon by physicians, patients, and payors;
- 22 c. Creating a body of deceptive, misleading and unsupported sales and
23 promotional training materials about opioids that (a) understated the
24 risks and overstated the benefits of long-term use; (b) appeared to be the
25 result of independent, objective research; and (c) was thus more likely to
26 be relied upon by physicians, patients, and payors;
- 27 d. Creating a body of deceptive, misleading and unsupported CMEs and
28 speaker presentations about opioids that (a) understated the risks and

1 overstated the benefits of long-term use; (b) appeared to be the result of
2 independent, objective research; and (c) was thus more likely to be
3 relied upon by physicians, patients, and payors;

4 e. Selecting, cultivating, promoting and paying KOLs based solely on their
5 willingness to communicate and distribute the RICO Defendants' messages about
6 the use of opioids for chronic pain;

7 f. Providing substantial opportunities for KOLs to participate in research
8 studies on topics the RICO Defendants suggested or chose, with the predictable
9 effect of ensuring that many favorable studies appeared in the academic literature;

10 g. Paying KOLs to serve as consultants or on the RICO Defendants' advisory
11 boards, on the advisory boards and in leadership positions on Front Groups, and to
12 give talks or present CMEs, typically over meals or at conferences;

13 h. Selecting, cultivating, promoting, creating and paying Front Groups based
14 solely on their willingness to communicate and distribute the RICO Defendants'
15 messages about the use of opioids for chronic pain;

16 i. Providing substantial opportunities for Front Groups to participate in and/or
17 publish research studies on topics the RICO Defendants suggested or chose (and
18 paid for), with the predictable effect of ensuring that many favorable studies
19 appeared in the academic literature;

20 j. Paying significant amounts of money to the leaders and individuals
21 associated with Front Groups;

22 k. Donating to Front Groups to support talks or CMEs, that were typically
23 presented over meals or at conferences;

24 l. Disseminating many of their false, misleading, imbalanced, and
25 unsupported statements through unbranded materials that appeared to be
26 independent publications from Front Groups;

27

28

- 1 m. Sponsoring CME programs put on by Front Groups that focused
2 exclusively on the use of opioids for chronic pain;
- 3 n. Developing and disseminating pro-opioid treatment guidelines with the help
4 of the KOLs as authors and promoters, and the help of the Front Groups as
5 publishers, and supporters;
- 6 o. Encouraging Front Groups to disseminate their pro-opioid messages to
7 groups targeted by the RICO Defendants, such as veterans and the elderly, and
8 then funded that distribution;
- 9 p. Concealing their relationship to and control of Front Groups and KOLs
10 from the The County and the public at large; and
- 11 q. Intending that Front Groups and KOLs would distribute through the U.S.
12 mail and interstate wire facilities, promotional and other materials that claimed
13 opioids could be safely used for chronic pain.

14 580. The Front Groups also participated in the conduct of the Opioid
15 Marketing Enterprise, directly or indirectly, in the following ways:

- 16 a. The Front Groups promised to, and did, make representations regarding
17 opioids and the RICO Marketing Defendants' drugs that were consistent
18 with the RICO Marketing Defendants' messages;
- 19 b. The Front Groups distributed, through the U.S. Mail and interstate wire
20 facilities, promotional and other materials which claimed that opioids
21 could be safely used for chronic pain without addiction, and
22 misrepresented the benefits of using opioids for chronic pain outweighed
23 the risks;
- 24 c. The Front Groups echoed and amplified messages favorable to increased
25 opioid use—and ultimately, the financial interests of the RICO
26 Marketing Defendants;
- 27 d. The Front Groups issued guidelines and policies minimizing the risk of
28 opioid addiction and promoting opioids for chronic pain;

1 e. The Front Groups strongly criticized the 2016 guidelines from the
 2 Center for Disease Control and Prevention (CDC) that recommended
 3 limits on opioid prescriptions for chronic pain; and
 4 f. The Front Groups concealed their connections to the KOLs and the RICO
 5 Marketing Defendants.

6 581. The RICO Marketing Defendants' Front Groups, "with their large
 7 numbers and credibility with policymakers and the public—have 'extensive
 8 influence in specific disease areas.'" The RICO Marketing Defendants' larger
 9 Front Groups "likely have a substantial effect on policies relevant to their industry
 10 sponsors."³⁹⁸ "By aligning medical culture with industry goals in this way, many
 11 of the groups described in this report may have played a significant role in
 12 creating the necessary conditions for the U.S. opioid epidemic."³⁹⁹

13 582. The KOLs also participated, on information and belief, in the conduct
 14 of the affairs of the Opioid Marketing Enterprise, directly or indirectly, in the
 15 following ways:

- 16 a. The KOLs promised to, and did, make representations regarding opioids
 17 and the RICO Marketing Defendants' drugs that were consistent with the RICO
 18 Marketing Defendants' messages themselves;
- 19 b. The KOLs distributed, through the U.S. Mail and interstate wire facilities,
 20 promotional and other materials which claimed that opioids could be safely used
 21 for chronic pain without addiction, and misrepresented the benefits of using
 22 opioids for chronic pain outweighed the risks;
- 23 c. The KOLs echoed and amplified messages favorable to increased opioid
 24 use—and ultimately, the financial interests of the RICO Marketing Defendants;

26 ³⁹⁸ *Fueling an Epidemic: Exposing the Financial Ties Between Opioid*
 27 *Manufacturers and Third Party Advocacy Groups*, U.S. Senate Homeland Security
 28 & Governmental Affairs Committee, Ranking Members' Office, February 12,
 2018 <https://www.hslc.org/?abstract&did=808171> ("Fueling an Epidemic"), at 1.

399 *Id.* 2.

1 d. The KOLs issued guidelines and policies minimizing the risk of opioid
2 addiction and promoting opioids for chronic pain;

3 e. The KOLs strongly criticized the 2016 guidelines from the Center for
4 Disease Control and Prevention (CDC) that recommended limits on opioid
5 prescriptions for chronic pain; and

6 f. The KOLs concealed their connections to the Front Groups and the RICO
7 Defendants, and their sponsorship by the RICO Marketing Defendants.

8 583. The scheme devised and implemented by the RICO Marketing
9 Defendants and members of the Opioid Marketing Enterprise, amounted to a
10 common course of conduct intended to increase the RICO Marketing Defendants
11 sales from prescription opioids by encouraging the prescribing and use of opioids
12 for long-term chronic pain. The scheme was a continuing course of conduct, and
13 many aspects of it continue through to the present.

14 **C. PATTERN OF RACKETEERING ACTIVITY**

15 584. The RICO Marketing Defendants conducted and participated in the
16 conduct of the Opioid Marketing Enterprise through a pattern of racketeering
17 activity within the meaning of 18 U.S.C. § 1961(1) that employed the use of mail
18 and wire facilities, in violation of 18 U.S.C. § 1341 (mail fraud) and § 1343 (wire
19 fraud).

20 585. The RICO Marketing Defendants committed, conspired to commit,
21 and/or aided and abetted in the commission of at least two predicate acts of
22 racketeering activity (*i.e.* violations of 18 U.S.C. §§ 1341 and 1343) within the
23 past ten years. The multiple acts of racketeering activity that the RICO Marketing
24 Defendants committed, or aided and abetted in the commission of, were related to
25 each other, posed a threat of continued racketeering activity, and therefore
26 constitute a “pattern of racketeering activity.” The racketeering activity was made
27 possible by the RICO Marketing Defendants’ regular use of the facilities, services,
28 distribution channels, and employees of the Opioid Marketing Enterprise, the U.S.

1 Mail and interstate wire facilities. The RICO Marketing Defendants participated
2 in the scheme to defraud by using mail, telephones and the Internet to transmit
3 mailings and wires in interstate or foreign commerce.

4 586. The pattern of racketeering activity described herein used by the
5 RICO Marketing Defendants and the Opioid Marketing Enterprise likely involved
6 thousands of separate instances of the use of the U.S. Mail or interstate wire
7 facilities in furtherance of the unlawful Opioid Marketing Enterprise, including
8 virtually uniform misrepresentations, concealments and material omissions
9 regarding the beneficial uses and non-addictive qualities for the long-term
10 treatment of chronic, non-acute and non-cancer pain, with the goal of profiting
11 from increased sales of the RICO Marketing Defendants' drugs induced by
12 consumers, prescribers, regulators and the County's reliance on the RICO
13 Marketing Defendants' misrepresentations.

14 587. Each of these fraudulent mailings and interstate wire transmissions
15 constitutes racketeering activity and collectively, these violations constitute a
16 pattern of racketeering activity, through which Defendants, the Front Groups and
17 the KOLs defrauded and intended to defraud California consumers, the State, and
18 other intended victims.

19 588. In devising and executing the illegal scheme, the RICO Marketing
20 Defendants devised and knowingly carried out a material scheme and/or artifice to
21 defraud by means of materially false or fraudulent pretenses, representations,
22 promises, or omissions of material facts regarding the safe, non-addictive and
23 effective use of opioids for long-term chronic, non-acute and non-cancer pain.
24 The RICO Marketing Defendants and members of the Opioid Marketing
25 Enterprise knew that these representations violated the FDA approved use of these
26 drugs, and were not supported by actual evidence. For the purpose of executing
27 the illegal scheme, the RICO Marketing Defendants intended that their
28 common purpose and scheme to defraud would, and did, use the U.S. Mail and

1 interstate wire facilities, intentionally and knowingly with the specific intent to
2 advance their illegal scheme.

3 589. The RICO Marketing Defendants' predicate acts of racketeering (18
4 U.S.C. § 1961(1)) include, but are not limited to:

- 5 a. Mail Fraud: The RICO Marketing Defendants violated 18 U.S.C. § 1341
6 by sending or receiving, or by causing to be sent and/or received,
7 materials via U.S. mail or commercial interstate carriers for the purpose
8 of executing the unlawful scheme to design, manufacture, market, and
9 sell the prescription opioids by means of false pretenses,
10 misrepresentations, promises, and omissions.
- 11 b. Wire Fraud: The RICO Marketing Defendants violated 18 U.S.C. § 1343
12 by transmitting and/or receiving, or by causing to be transmitted and/or
13 received, materials by wire for the purpose of executing the unlawful
14 scheme to design, manufacture, market, and sell the prescription opioids
15 by means of false pretenses, misrepresentations, promises, and
16 omissions.

17 590. Each instance of racketeering activity alleged herein was related, had
18 similar purposes, involved the same or similar participants and methods of
19 commission, and had similar results affecting similar victims, including California
20 consumers, prescribers, regulators and The County. The RICO Marketing
21 Defendants, Front Groups and KOLs calculated and intentionally crafted the
22 scheme and common purpose of the Opioid Marketing Enterprise to ensure their
23 own profits remained high. In designing and implementing the scheme, the RICO
24 Marketing Defendants understood and intended that those in the distribution chain
25 rely on the integrity of the pharmaceutical companies and ostensibly neutral third
26 parties to provide objective and scientific evidence regarding the RICO Marketing
27 Defendants' products.

28

1 591. By intentionally misrepresenting the risks and benefits of using
2 opioids for chronic pain, and then subsequently failing to disclose such practices
3 to California consumers, prescribers, regulators and The County. Defendants, the
4 Front Groups and the KOLs engaged in a fraudulent and unlawful course of
5 conduct constituting a pattern of racketeering activity.

6 592. The racketeering activities conducted by the RICO Marketing
7 Defendants, Front Groups and KOLs amounted to a common course of conduct,
8 with a similar pattern and purpose, intended to deceive California consumers,
9 prescribers, regulators and The County. Each separate use of the U.S. Mail and/or
10 interstate wire facilities employed by Defendants was related, had similar intended
11 purposes, involved similar participants and methods of execution, and had the
12 same results affecting the same victims, including California consumers,
13 prescribers, regulators and The County. The RICO Marketing Defendants have
14 engaged in the pattern of racketeering activity for the purpose of conducting the
15 ongoing business affairs of the Opioid Marketing Enterprise.

16 593. The RICO Marketing Defendants' pattern of racketeering activity
17 alleged herein and the Opioid Marketing Enterprise are separate and distinct from
18 each other. Likewise, the RICO Marketing Defendants are distinct from the
19 Opioid Marketing Enterprise.

20 594. The pattern of racketeering activity alleged herein is continuing as of
21 the date of this complaint, and, upon information and belief, will continue into the
22 future unless enjoined by this Court.

23 595. Many of the precise dates of the Opioid Marketing Enterprise's uses
24 of the U.S. Mail and interstate wire facilities (and corresponding predicate acts of
25 mail and wire fraud) have been hidden and cannot be alleged without access to the
26 books and records maintained by the RICO Marketing Defendants, Front Groups,
27 and KOLs. Indeed, an essential part of the successful operation of the Opioid
28 Marketing Enterprise alleged herein depended upon secrecy. However, Plaintiffs

1 have described the occasions on which the RICO Marketing Defendants, Front
2 Groups, and KOLs disseminated misrepresentations and false statements to
3 California consumers, prescribers, regulators and The County, and how those acts
4 were in furtherance of the scheme, and do so further below.

5 596. The RICO Marketing Defendants' use of the U.S. Mail and interstate
6 wire facilities to perpetrate the opioids marketing scheme involved thousands of
7 communications, publications, representations, statements, electronic
8 transmissions, payments, including, *inter alia*:

- 9 a. Marketing materials about opioids, and their risks and benefits, which
10 the RICO Marketing Defendants sent to health care providers,
11 transmitted through the internet and television, published, and
12 transmitted to Front Groups and KOLs located across the country and
13 the State;
- 14 b. Written representations and telephone calls between the RICO
15 Marketing Defendants and Front Groups regarding the
16 misrepresentations, marketing statements and claims about opioids,
17 including the non-addictive, safe use of chronic long-term pain
18 generally;
- 19 c. Written representations and telephone calls between the RICO
20 Marketing Defendants and KOLs regarding the misrepresentations,
21 marketing statements and claims about opioids, including the non-
22 addictive, safe use of chronic long-term pain generally;
- 23 d. E-mails, telephone and written communications between the RICO
24 Marketing Defendants and the Front Groups agreeing to or
25 implementing the opioids marketing scheme;
- 26 e. E-mails, telephone and written communications between the RICO
27 Marketing Defendants and the KOLs agreeing to or implementing the
28 opioids marketing scheme;

- 1 f. Communications between the RICO Marketing Defendants, Front
- 2 Groups and the media regarding publication, drafting of treatment
- 3 guidelines, and the dissemination of the same as part of the Opioid
- 4 Marketing Enterprise;
- 5 g. Communications between the RICO Marketing Defendants, KOLs and
- 6 the media regarding publication, drafting of treatment guidelines, and
- 7 the dissemination of the same as part of the Opioid Marketing
- 8 Enterprise;
- 9 h. Written and oral communications directed to State agencies, federal and
- 10 state courts, and private insurers throughout the State that fraudulently
- 11 misrepresented the risks and benefits of using opioids for chronic pain;
- 12 and
- 13 i. Receipts of increased profits sent through the U.S. Mail and interstate
- 14 wire facilities – the wrongful proceeds of the scheme.

15 597. In addition to the above-referenced predicate acts, it was foreseeable
16 to the RICO Marketing Defendants that the Front Groups and the KOLs would
17 distribute publications through the U.S. Mail and by interstate wire facilities, and,
18 in those publications, claim that the benefits of using opioids for chronic pain
19 outweighed the risks of doing so.

20 598. The RICO Marketing Defendants aided and abetted others in the
21 violations of the above laws, thereby rendering them indictable as principals in the
22 18 U.S.C. §§ 1341 and 1343 offenses.

23 599. To achieve the common goal and purpose of the Opioid Marketing
24 Enterprise, the RICO Marketing Defendants and members of the Opioid
25 Marketing Enterprise hid from the consumers, prescribers, regulators and The
26 County: (1) the fraudulent nature of the RICO Marketing Defendants' marketing
27 scheme; (2) the fraudulent nature of statements made by the RICO Marketing
28 Defendants and by their KOLs, Front Groups and other third parties regarding the

1 safety and efficacy of prescription opioids; and (3) the true nature of the
2 relationship between the members of the Opioid Marketing Enterprise.

3 600. The RICO Marketing Defendants, and each member of the Opioid
4 Marketing Enterprise agreed, with knowledge and intent, to the overall objective
5 of the RICO Marketing Defendants' fraudulent scheme and participated in the
6 common course of conduct to commit acts of fraud and indecency in marketing
7 prescription opioids.

8 601. Indeed, for the RICO Marketing Defendants' fraudulent scheme to
9 work, each of the RICO Marketing Defendants had to agree to implement similar
10 tactics regarding fraudulent marketing of prescription opioids. This conclusion is
11 supported by the fact that the RICO Marketing Defendants each financed,
12 supported, and worked through the same KOLs and Front Groups, and often
13 collaborated on and mutually supported the same publications, CMEs,
14 presentations, and prescription guidelines.

15 602. As described herein, the RICO Marketing Defendants engaged in a
16 pattern of related and continuous predicate acts for years. The predicate acts
17 constituted a variety of unlawful activities, each conducted with the common
18 purpose of obtaining significant money and revenue from the marketing and sale
19 of their highly addictive and dangerous drugs. The predicate acts also had the
20 same or similar results, participants, victims, and methods of commission. The
21 predicate acts were related and not isolated events.

22 603. The RICO Marketing Defendants predicate acts all had the purpose
23 of creating the opioid epidemic that substantially injured The County's business
24 and property, while simultaneously generating billion-dollar revenue and profits
25 for the RICO Marketing Defendants. The predicate acts were committed or caused
26 to be committed by the RICO Marketing Defendants through their participation in
27 the Opioid Marketing Enterprise and in furtherance of its fraudulent scheme.

28

1 604. The RICO Marketing Defendants' predicate acts and pattern of
 2 racketeering activity were a substantial and foreseeable cause of The County's
 3 injury and the relationship between the RICO Marketing Defendants' conduct and
 4 The County's injury is logical and not speculative. It was foreseeable to the RICO
 5 Marketing Defendants that when they fraudulently marketed highly-addictive and
 6 dangerous drugs, that were approved for very limited and specific uses by the
 7 FDA, as non-addictive and safe for off-label uses such as moderate pain, non-
 8 cancer pain, and long-term chronic pain, that the RICO Marketing Defendants
 9 would create an opioid-addiction epidemic that logically, substantially and
 10 foreseeably harmed The County.

11 605. The pattern of racketeering activity alleged herein is continuing as of
 12 the date of this Complaint and, upon information and belief, will continue into the
 13 future unless enjoined by this Court. The last racketeering incident occurred
 14 within five years of the commission of a prior incident of racketeering.

15 **D. DAMAGES.**

16 **1. Impact of the Opioid Marketing Enterprise.**

17 606. California has been especially ravaged by the national opioid crisis.

18 607. More people die each year from drug overdoses in California than in
 19 any other state.⁴⁰⁰ The State's death rate has continued to climb, increasing by 30
 20 percent from 1999 to 2015, according to the Center for Disease Control (CDC).⁴⁰¹

21 608. In 2016, 1,925 Californians died due to prescription opioids.⁴⁰² This
 22 number is on par with other recent years: in 2015, 1,966 deaths in California were
 23 due just to prescription opioids (not including heroin); in 2014 that number was

24
 25
 26
 27 ⁴⁰⁰ Davis, *supra*.

28 ⁴⁰¹ Karlamangla, *supra*.

29 ⁴⁰² Davis, *supra*.

1 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians
 2 died from a prescription opioid overdose.⁴⁰³

3 609. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was
 4 a factor in at least 234 of them.⁴⁰⁴ This is an increase of 47 percent for 2016.⁴⁰⁵
 5 Heroin-related deaths have risen by 67 percent in California since 2006.⁴⁰⁶

6 610. The high number of deaths are due in part to the extraordinary
 7 number of opioids prescribed in the State. Over 23.6 million prescriptions for
 8 opioids were written in California in just 2016.⁴⁰⁷

9 611. The California Department of Public Health tracks the number of
 10 reported hospitalizations and emergency department visits due to prescription
 11 opioids.⁴⁰⁸ In 2015, the last year for which information is currently available,
 12 California had 3,935 emergency department visits and 4,095 hospitalizations
 13 related to prescription opioid overdoses (excluding heroin).⁴⁰⁹ The numbers were
 14 even higher in 2014, when 4,106 people visited the emergency department and
 15 4,482 people were hospitalized due to prescription opioid abuse.⁴¹⁰ In 2013, there
 16 were 3,964 emergency department visits and 4,344 hospitalizations for
 17
 18

19
 20 ⁴⁰³California Department of Public Health, *California Opioid Overdose*
Surveillance Dashboard, *supra*.

21 ⁴⁰⁴ Davis, *supra*.

22 ⁴⁰⁵ Karlamangla, *supra*.

23 ⁴⁰⁶ California Department of Public Health, *State of California Strategies to*
Address Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in
California at 3 (June 2016), available at
 24 <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

25 ⁴⁰⁷ California Department of Public Health, *California Opioid Overdose*
Surveillance Dashboard, *supra*.

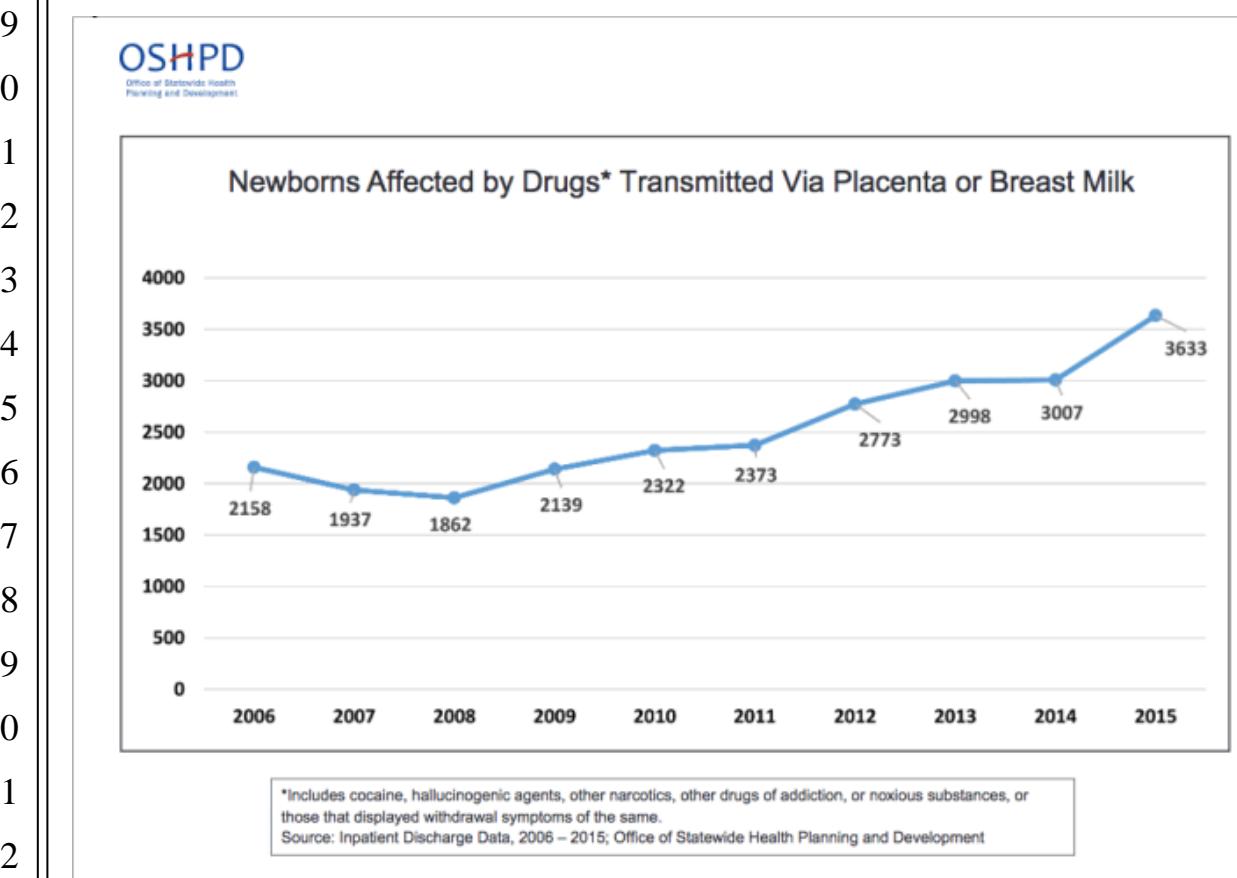
26 ⁴⁰⁸ *Id.*

27 ⁴⁰⁹ *Id.*

28 ⁴¹⁰ *Id.*

1 prescription opioid overdoses.⁴¹¹ When emergency visits and hospitalizations
 2 include heroin, the numbers are even higher.⁴¹²

3 612. Neonatal Abstinence Syndrome (NAS) has increased dramatically in
 4 California, with the rate of infants born with NAS more than tripling from 2008 to
 5 2013.⁴¹³ While the number of affected newborns rose from 1,862 in 2008 to 3,007
 6 in 2014, that number jumped by another 21 percent in 2015.⁴¹⁴ This is despite a
 7 steady decline in the overall number of births in California during that same
 8 time.⁴¹⁵



⁴¹¹ *Id.*

⁴¹² *Id.*

⁴¹³ California Child Welfare Co-Investment Partnership, *supra* at 5.

⁴¹⁴ Clark, *supra*.

⁴¹⁵ *Id.*

1 613. Reports from California's Office of Statewide Health Planning,
 2 which collects data from licensed health care facilities, have shown a 95 percent
 3 increase between 2008 and 2015 of newborns affected by drugs transmitted via
 4 placenta or breast milk.⁴¹⁶

5 614. The opioid epidemic has also had an impact on crime in California.
 6 Pharmacy robberies have gone up by 163 percent in California over the last two
 7 years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in
 8 2016 and, through mid-November of 2017, that number had climbed to 237.⁴¹⁷
 9 Most perpetrators were after prescription opioids.⁴¹⁸ In addition, fentanyl seizures
 10 at California ports increased 266 percent in fiscal year 2017.⁴¹⁹

11 615. The opioid epidemic is particularly devastating in Plaintiffs'
 12 Community.

13 616. In 2016, the County had an opioid overdose death rate of 13.4, the
 14 eighth highest in the State.⁴²⁰ In 2015, the County's opioid overdose death rate
 15 was in the highest quartile in the State.⁴²¹

16 617. Prescription opioids have also been responsible for a high rate of
 17 emergency department visits in the County. In 2016, Trinity County had a rate of
 18

19 ⁴¹⁶ California Child Welfare Co-Investment Partnership, *supra*.

20 ⁴¹⁷ Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at
 21 <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited
 March 2, 2018)).

22 ⁴¹⁸ *Id.*

23 ⁴¹⁹ United States Department of Justice, The United States Attorney's Office,
 24 Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb.
 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

25 ⁴²⁰ California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last visited April 23, 2018) (Trinity County specific page).

27 ⁴²¹ Public Health Institute, Tackling An Epidemic: An Assessment of the California Opioid Safety Coalitions Network, at p. 11, available at
 28 <https://www.phi.org/uploads/application/files/bt93oju0nrnbsmjhpdw692ljgu0d27ttdpzxmbclj7cxq99alz.pdf> (last visited April 20, 2018).

1 40.8 emergency department visits due to opioid overdoses (excluding heroin) per
 2 100,000 people, the fourth highest rate in the State that year.⁴²²

3 618. In 2016, an estimated seven percent of the population aged 12 and up
 4 in Trinity County misused opioids and about 1.3 percent had an opioid use
 5 disorder.⁴²³

6 619. The CDC has tracked prescription rates per county in the United
 7 States, identifying the geographic “hotspots” for rates of opioid prescriptions.⁴²⁴
 8 The CDC has calculated the geographic distribution at county levels of opioid
 9 prescriptions dispensed per 100 persons,⁴²⁵ revealing that Trinity County has been
 10 a consistent hotspot over at least the past decade.

11 620. The CDC’s statistics prove that the opioid prescription rates in
 12 Trinity County have exceeded any legitimate medical, scientific, or industrial
 13 purpose. The overall opioid prescribing rate in 2016 was 66.5 prescriptions per
 14 100 people and 44.8 in California.⁴²⁶ However, in Trinity County, California, the
 15 2016 prescription rate was 98.5 per 100 people.⁴²⁷ This is down from the 2015

16
 17
 18
 19 ⁴²² California Department of Public Health, *California Opioid Overdose*
 Surveillance Dashboard, available at https://pdop.shinyapps.io/ODdash_v1/ (last
 20 visited April 20, 2018) (Trinity County specific page).

21 ⁴²³ Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, “County-Level
 Estimates of Opioid Use Disorder and Treatment Needs in California,” *The Urban*
 22 *Institute*, March 19, 2018, available at
<https://www.urban.org/sites/default/files/trinity.pdf> (last visited April 23, 2018).

23 ⁴²⁴ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 24 2017).

25 ⁴²⁵ *Id.*

26 ⁴²⁶ *Id.* See also U.S. State Prescribing Rates, 2016, available at
<https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,
 27 2018).

28 ⁴²⁷ U.S. County Prescribing Rates, 2016, (reporting for “Trinity, CA” here and
 below) CDC available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,
 2018).

1 prescribing rate for Trinity County which was 110.2 per 100 people – more than
 2 one prescription for every man, woman and child in Trinity County.⁴²⁸

3 621. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions
 4 were not an aberration for Trinity County. Consistently, the opioid prescribing
 5 rates in Trinity County have been significantly greater than the national and state
 6 averages, and well more than one prescription per person living in the County.
 7 Compared to a national average of 75.6 opioid prescriptions per 100 people in
 8 2014⁴²⁹ and 52.7 in California,⁴³⁰ the Trinity County opioid prescription rate was
 9 119.6 per 100 people, more than double the State prescribing rate.⁴³¹ In 2013, the
 10 national average was 78.1 opioid prescriptions per 100 people,⁴³² but the opioid
 11 prescription rate in Trinity County was 117 per 100 people.⁴³³ Compared to a
 12 national average of 81.3 opioid prescriptions per 100 people in 2012,⁴³⁴ the opioid
 13 prescription rate in Trinity County was 126.7 per 100 people that year.⁴³⁵ In 2011,

14

15 ⁴²⁸ U.S. County Prescribing Rates, 2015, CDC, available at
 16 <https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,
 17 2018).

18 ⁴²⁹ U.S. Prescribing Rate Maps, CDC, available at
 19 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 20 2017).

21 ⁴³⁰ U.S. State Prescribing Rates, 2014, CDC, available at
 22 <https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,
 23 2017).

24 ⁴³¹ U.S. County Prescribing Rates, 2014, CDC, available at
 25 <https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,
 26 2018).

27 ⁴³² U.S. Prescribing Rate Maps, CDC, available at
 28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 29 2017).

30 ⁴³³ U.S. County Prescribing Rates, 2013, CDC, available at
 31 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,
 32 2018).

33 ⁴³⁴ U.S. Prescribing Rate Maps, CDC, available at
 34 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 35 2017).

36 ⁴³⁵ U.S. County Prescribing Rates, 2012, CDC, available at
 37 <https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,
 38 2018).

1 the national average was 80.9 opioid prescriptions per 100 people,⁴³⁶ but the
2 opioid prescription rate in Trinity County was 135.6 per 100 people.⁴³⁷ Compared
3 to a national average of 81.2 opioid prescriptions per 100 people in 2010,⁴³⁸ the
4 Trinity County opioid prescription rate was 144.9 per 100 people.⁴³⁹ In 2009, the
5 national average was 79.5 opioid prescriptions per 100 people,⁴⁴⁰ but the rate in
6 Trinity County was 121.4 per 100.⁴⁴¹ Compared to a national average of 78.2
7 opioid prescriptions per 100 people in 2008⁴⁴² and 55.1 in California,⁴⁴³ the
8 Trinity County rate was 116.8 per 100 people.⁴⁴⁴ In 2007, the national average
9 was 75.9 opioid prescriptions per 100 people,⁴⁴⁵ but the Trinity County rate was
10

11 _____
12 ⁴³⁶ U.S. Prescribing Rate Maps, CDC, available at
13 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
14 2017).

15 ⁴³⁷ U.S. County Prescribing Rates, 2011, CDC, available at
16 <https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,
17 2018).

18 ⁴³⁸ U.S. Prescribing Rate Maps, CDC, available at
19 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
20 2017).

21 ⁴³⁹ U.S. County Prescribing Rates, 2010, CDC, available at
22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18,
23 2018).

24 ⁴⁴⁰ U.S. Prescribing Rate Maps, CDC, available at
25 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
26 2017).

27 ⁴⁴¹ U.S. County Prescribing Rates, 2009, CDC, available at
28 <https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18,
29 2018).

⁴⁴² U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
2017).

⁴⁴³ U.S. State Prescribing Rates, 2018, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11,
2017).

⁴⁴⁴ U.S. County Prescribing Rates, 2008, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18,
2018).

⁴⁴⁵ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,,
2017).

1 117.9 per 100 people.⁴⁴⁶ Compared to a national average of 72.4 opioid
 2 prescriptions per 100 people prescribed opioids in 2006,⁴⁴⁷ the Trinity County rate
 3 was 120.5 per 100 people.⁴⁴⁸

4 **2. Relief Sought.**

5 622. The RICO Marketing Defendants' violations of law and their pattern
 6 of racketeering activity directly and proximately caused The County injury in its
 7 business and property. The RICO Marketing Defendants' pattern of racketeering
 8 activity logically, substantially and foreseeably caused an opioid epidemic. The
 9 County's injuries, as described below, were not unexpected, unforeseen or
 10 independent.⁴⁴⁹ Rather, as Plaintiffs allege, the RICO Marketing Defendants
 11 knew that the opioids were unsuited to treatment of long-term chronic, non-acute,
 12 and non-cancer pain, or for any other use not approved by the FDA, and knew that
 13 opioids were highly addictive and subject to abuse.⁴⁵⁰ Nevertheless, the RICO
 14 Marketing Defendants engaged in a scheme of deception, that utilized the mail
 15 and wires as part of their fraud, in order to increase sales of their opioid products.

16 623. It was foreseeable and expected that a massive marketing campaign
 17 utilized by the RICO Marketing Defendants that misrepresented the non-addictive
 18 and effective use of prescription opioids for purposes for which they are not suited
 19 and not approved by the FDA would lead to a nationwide opioid epidemic.⁴⁵¹ It
 20

21 ⁴⁴⁶ U.S. County Prescribing Rates, 2007, CDC, available at
 22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18,
 2018).

23 ⁴⁴⁷ U.S. Prescribing Rate Maps, CDC, available at
 24 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

25 ⁴⁴⁸ U.S. County Prescribing Rates, 2006, CDC, available at
 26 <https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18,
 2018).

27 ⁴⁴⁹ Traveler's Property Casualty Company of America v. Actavis, Inc., 22 Cal.
 28 Rptr. 3d 5, 19 (Cal. Ct. App. 2017).

⁴⁵⁰ *Id.*

⁴⁵¹ *Id.*

1 was also foreseeable and expected that the RICO Marketing Defendants' 2 marketing campaign would lead to increased opioid addiction and overdose.⁴⁵² 3 The County's injuries were logically, foreseeable, and substantially caused by the 4 opioid epidemic that the RICO Marketing Defendants created.

5 624. Specifically, the RICO Marketing Defendants' predicate acts and 6 pattern of racketeering activity caused the opioid epidemic which has injured The 7 County in the form of substantial losses of money and property that logically, 8 directly and foreseeably arise from the opioid-addiction epidemic. The County's 9 injuries, as alleged throughout this complaint, and expressly incorporated herein 10 by reference, include:

- 11 a. Losses caused by purchasing and/or paying reimbursements for the
12 RICO Marketing Defendants' prescription opioids, that The County
13 would not have paid for or purchased but for the RICO Marketing
14 Defendants' conduct;
- 15 b. Losses caused by the decrease in funding available for The County's
16 public services for which funding was lost because it was diverted to
17 other public services designed to address the opioid epidemic;
- 18 c. Costs for providing healthcare and medical care, additional therapeutic,
19 and prescription drug purchases, and other treatments for patients
20 suffering from opioid-related addiction or disease, including overdoses
21 and deaths;
- 22 d. Costs of training emergency and/or first responders in the proper
23 treatment of drug overdoses;
- 24 e. Costs associated with providing police officers, firefighters, and
25 emergency and/or first responders with Naloxone – an opioid antagonist
26 used to block the deadly effects of opioids in the context of overdose;

27
28 ⁴⁵² *Id.*

- 1 f. Costs associated with emergency responses by police officers,
2 firefighters, and emergency and/or first responders to opioid overdoses;
- 3 g. Costs for providing mental-health services, treatment, counseling,
4 rehabilitation services, and social services to victims of the opioid
5 epidemic and their families;
- 6 h. Costs for providing treatment of infants born with opioid-related medical
7 conditions, or born addicted to opioids due to drug use by mother during
8 pregnancy;
- 9 i. Costs associated with law enforcement and public safety relating to the
10 opioid epidemic, including but not limited to attempts to stop the flow of
11 opioids into local communities, to arrest and prosecute street-level
12 dealers, to prevent the current opioid epidemic from spreading and
13 worsening, and to deal with the increased levels of crimes that have
14 directly resulted from the increased homeless and drug-addicted
15 population;
- 16 j. Costs associated with increased burden on the County's judicial system,
17 including increased security, increased staff, and the increased cost of
18 adjudicating criminal matters due to the increase in crime directly
19 resulting from opioid addiction;
- 20 k. Costs associated with providing care for children whose parents suffer
21 from opioid-related disability or incapacitation;
- 22 l. Loss of tax revenue due to the decreased efficiency and size of the
23 working population in Plaintiffs' Community;
- 24 m. Losses caused by diminished property values in neighborhoods where
25 the opioid epidemic has taken root; and
- 26 n. Losses caused by diminished property values in the form of decreased
27 business investment and tax revenue.

1 625. The County's injuries were proximately caused by the RICO
2 Marketing Defendants' racketeering activities because they were the logical,
3 substantial and foreseeable cause of The County's injuries. But for the opioid-
4 addiction epidemic created by the RICO Marketing Defendants' conduct, The
5 County would not have lost money or property.

6 626. The County's injuries were directly caused by the RICO Marketing
7 Defendants' pattern of racketeering activities.

8 627. The County is the most directly harmed entity and there is no other
9 Plaintiff better suited to seek a remedy for the economic harms at issue here.

10 628. Plaintiff seeks all legal and equitable relief as allowed by law,
11 including *inter alia* actual damages, treble damages, equitable relief, forfeiture as
12 deemed proper by the Court, attorney's fees and all costs and expenses of suit and
13 pre- and post-judgment interest.

COUNT IV

RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT

18 U.S.C. 1961, et seq.

**(Against Defendants Purdue, Cephalon, Endo, Mallinckrodt, Actavis,
McKesson, Cardinal, and AmerisourceBergen)**

(The “Opioid Diversion Enterprise”)

20 629. Plaintiff, The County, hereby incorporates by reference all other
21 paragraphs of this Complaint as if fully set forth herein, and further alleges as
22 follows.

23 630. The County brings this Claim against the following Defendants, as
24 defined above: Purdue, Cephalon, Endo, Mallinckrodt, Actavis (the
25 “Manufacturer Defendants”), McKesson, Cardinal, and AmerisourceBergen (the
26 “Distributor Defendants”) (collectively, for purposes of this Claim, the “RICO
27 Diversion Defendants”).

1 631. The RICO Diversion Defendants conducted and continue to conduct
2 their business through legitimate and illegitimate means in the form of an
3 association-in-fact enterprise and/or a legal entity enterprise as defined in 18
4 U.S.C. § 1961(4). Alternatively, the RICO Diversion Defendants were members
5 of a legal entity enterprise within the meaning of 18 U.S.C. § 1961(4).
6 Specifically, each of the RICO Diversion Defendants was a member of the
7 Healthcare Distribution Alliance (the “HDA”)⁴⁵³ which is a distinct legal entity
8 that satisfies the definition of a RICO enterprise because it is a non-profit
9 corporation and, therefore, and “enterprise” within the definition set out in 18
10 U.S.C. § 1961(4). On information and belief, each of the RICO Diversion
11 Defendants is a member, participant, and/or sponsor of the HDA and utilized the
12 HDA to conduct the Opioid Diversion Enterprise and to engage in the pattern of
13 racketeering activity that gives rise to this cause of action. The legal and
14 association-in-fact enterprises alleged in the previous and subsequent paragraphs
15 are pleaded in the alternative and are collectively referred to as the “Opioid
16 Diversion Enterprise.”

17 632. For over a decade, the RICO Diversion Defendants aggressively
18 sought to bolster their revenue, increase profit, and grow their share of the
19 prescription painkiller market by unlawfully and surreptitiously increasing the
20 volume of opioids they sold. However, the RICO Diversion Defendants are not
21 permitted to engage in a limitless expansion of their sales through the unlawful
22 sales of regulated painkillers. As “registrants” under the Controlled Substances
23 Act, 21 U.S.C. § 821, *et seq.* (the “CSA”), the RICO Diversion Defendants
24 operated and continue to operate within a “closed-system.” The CSA restricts the
25 RICO Diversion Defendants’ ability to manufacture or distribute Schedule II
26

27

⁴⁵³ Health Distribution Alliance, History, Health Distribution Alliance, (last
28 accessed on September 15, 2017), <https://www.healthcaredistribution.org/about/hda-history>.

1 substances like opioids by: (1) requiring them to make sales within a limited quota
 2 set by the DEA for the overall production of Schedule II substances like opioids;
 3 (2) register to manufacture or distribute opioids; (3) maintain effective controls
 4 against diversion of the controlled substances that they manufacturer or distribute;
 5 and (4) design and operate a system to identify suspicious orders of controlled
 6 substances, halt such unlawful sales, and report them to the DEA.

7 633. The closed-system created by the CSA, and the establishment of
 8 quotas, was specifically intended to reduce or eliminate the diversion of Schedule
 9 II substances like opioids from “legitimate channels of trade” to the illicit market
 10 by controlling the “quantities of the basic ingredients needed for the manufacture
 11 of [controlled substances].”⁴⁵⁴

12 634. Finding it impossible to legally achieve their ever increasing sales
 13 ambitions, members of the Opioid Diversion Enterprise (defined below) engaged
 14 in the common purpose of fraudulently increasing the quotas that governed the
 15 manufacture and distribution of their prescription opioids. The RICO Diversion
 16 Defendants formed and pursued their common purpose through the many personal
 17 interactions that they had, confidentially, in organizations like the Pain Care
 18 Forum and the Healthcare Distribution Alliance.

19 635. The RICO Diversion Defendants’ common purpose and fraudulent
 20 scheme to unlawfully increase the DEA quotas violated the RICO Act in two
 21 ways. First, the RICO Diversion Defendants violated the RICO Act because they
 22 engaged in the felonious manufacture, buying selling, or otherwise dealing in
 23 controlled substances that are punishable by law in the United States.
 24 Specifically, the RICO Diversion Defendants “furnish[ed] false or fraudulent

25
 26 ⁴⁵⁴ 1970 U.S.C.C.A.N. 4566 at 5490; *see also* Testimony of Joseph T. Rannazzisi
 27 before the Caucus on International Narcotics Control, United States Senate, May 5,
 28 2015 (available at https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf).

1 material information in, or omit[ted] material information from, applications,
2 reports, records, and other document required to be made, kept, and filed under 21
3 U.S.C. §§ 801, et seq.”, in violation of 21 U.S.C. § 843(b), which is a felony.
4 Second, the RICO Diversion Defendants violated the RICO Act by engaging in
5 mail and wire fraud. The RICO Diversion Defendants common purpose and
6 fraudulent scheme was intended to, and did, utilize interstate mail and wire
7 facilities for the commission of their fraud in violation 18 U.S.C. §§ 1341 (mail
8 fraud) and 1343 (wire fraud).

9 636. The RICO Diversion Defendants’ fraudulent scheme arises at the
10 intersection between the quotas governing the RICO Diversion Defendants’
11 prescription opioids and the RICO Diversion Defendants’ duty to identify, report,
12 and halt suspicious orders of controlled substances. The RICO Diversion
13 Defendants’ formed an enterprise with the intent to fraudulently increase the
14 quotas for prescription opioids by refusing to identify, report and halt suspicious
15 orders, thereby omitting both the fact and the RICO Diversion Defendants’
16 knowledge of widespread diversion of prescription opioids into illegitimate
17 channels.

18 637. The RICO Diversion Defendants engaged in systematic and
19 fraudulent acts as part of the Opioid Diversion Enterprise, that furnished false or
20 fraudulent material information in, and omitted material information from their
21 applications, reports, records and other documents that the RICO Defendants were
22 required to make, keep and/or file. Furthermore, the RICO Diversion Defendants
23 engaged in systematic and fraudulent acts as part of the Opioid Diversion
24 Enterprise that were intended to and actually did utilize the mail and wire facilities
25 of the United States and California, including refusing to maintain effective
26 controls against diversion of their drugs, to design and operate a system to identify
27
28

1 suspicious orders of their drugs, to halt unlawful sales of suspicious orders, and to
 2 notify the DEA of suspicious orders.⁴⁵⁵

3 638. Through the RICO Diversion Defendants' scheme, members of the
 4 Opioid Diversion Enterprise repeatedly requested increases of the quotas
 5 governing the manufacture, sale and distribution of prescription opioids,
 6 misrepresented that they were complying with their duties under the CSA,
 7 furnished false or fraudulent material information in, and omitted material
 8 information from their applications, reports, records and other documents,
 9 engaged in unlawful sales of painkillers that resulted in diversion of controlled
 10 substances through suspicious orders, and refused to identify or report suspicious
 11 orders of controlled substances sales to the DEA.⁴⁵⁶ Defendants' refusal to report
 12 suspicious orders resulted in artificial and illegal increases in the annual
 13 production quotas for opioids allowed by the DEA. The end result of the RICO
 14 Diversion Defendants' fraudulent scheme and common purpose was continually
 15 increasing quotas that generated obscene profits and, in turn, fueled an opioid
 16 epidemic.

17 639. The RICO Diversion Defendants' illegal scheme was hatched by an
 18 enterprise between the Manufacturer Defendants and the Distributor Defendants,
 19 and executed in perfect harmony by each of them. In particular, each of the RICO
 20 Diversion Defendants were associated with, and conducted or participated in, the
 21 affairs of the Opioid Diversion Enterprise, whose common purpose was
 22 fraudulently increase the quotas governing the manufacture and sale of
 23 prescription opioids.

24 640. The success of the RICO Diversion Defendants' scheme allowed
 25 them to unlawfully increase and/or maintain high production quotas and, as a
 26
 27

28⁴⁵⁵ 21 U.S.C. § 823(a)(1), (b)(1); 21 C.F.R. § 1301.74(b)-(c).

⁴⁵⁶ 21 C.F.R. § 1303.11(b); 21 C.F.R. § 1303.23.

1 direct result, allowed them to make billions from the unlawful sale and diversion
 2 of opioids.

3 641. Simultaneously, the opioid epidemic created by the RICO Diversion
 4 Defendants' actions caused The County's multi-million dollar injuries. The
 5 County's injuries were and is a reasonably foreseeable consequence of the
 6 prescription opioid addiction epidemic that the RICO Diversion Defendants
 7 created by fraudulently increasing quotas, misrepresenting their compliance with
 8 their duties under the CSA, and allowing the widespread diversion of legally
 9 produced prescription opioids into the illicit market. As explained in detail below,
 10 the RICO Diversion Defendants' misconduct violated Section 1962(c) and the
 11 County is entitled to treble damages for their injuries under 18 U.S.C. § 1964(c).

A. THE OPIOID DIVERSION ENTERPRISE.

13 642. Recognizing that there is a need for greater scrutiny over controlled
 14 substances due to their potential for abuse and danger to public health and safety,
 15 the United States Congress enacted the Controlled Substances Act in 1970.⁴⁵⁷ The
 16 CSA and its implementing regulations created a closed-system of distribution for
 17 all controlled substances and listed chemicals.⁴⁵⁸ Congress specifically designed
 18 the closed chain of distribution to prevent the diversion of legally produced
 19 controlled substances into the illicit market.⁴⁵⁹ Congress was concerned with the
 20 diversion of drugs out of legitimate channels of distribution and acted to halt the
 21 "widespread diversion of [controlled substances] out of legitimate channels into
 22 the illegal market."⁴⁶⁰ Moreover, the closed-system was specifically designed to

24⁴⁵⁷ Joseph T. Rannazzisi Decl. ¶ 4, *Cardinal Health, Inc. v. Eric Holder, Jr., Attorney General*, D.D.C. Case No. 12-cv-185 (Document 14-2 February 10, 2012).

25⁴⁵⁸ See H.R. Rep. No. 91-1444, 1970 U.S.C.C.A.N. at 4566.

26⁴⁵⁹ *Gonzalez v. Raich*, 545 U.S. 1, 12-14 (2005); 21 U.S.C. § 801(20; 21 U.S.C. §§ 821-824, 827, 880; H.R. Rep. No. 91-1444, 1970 U.S.C.C.A.N. 4566, 4572 (Sept. 10, 1970).

28⁴⁶⁰ See Testimony of Joseph T. Rannazzisi before the Caucus on International Narcotics Control, United States Senate, May 5, 2015 (available at

1 ensure that there are multiple ways of identifying and preventing diversion
 2 through active participation by registrants within the drug delivery chain.⁴⁶¹ All
 3 registrants -- manufacturers and distributors alike -- must adhere to the specific
 4 security, recordkeeping, monitoring and reporting requirements that are designed
 5 to identify or prevent diversion.⁴⁶² When registrants at any level fail to fulfill their
 6 obligations, the necessary checks and balances collapse.⁴⁶³ The result is the
 7 scourge of addiction that has occurred

8 643. Central to the closed-system created by the CSA was the directive
 9 that the DEA determine quotas of each basic class of Schedule I and II controlled
 10 substances each year. The quota system was intended to reduce or eliminate
 11 diversion from “legitimate channels of trade” by controlling the “quantities of the
 12 basic ingredients needed for the manufacture of [controlled substances], and the
 13 requirement of order forms for all transfers of these drugs.”⁴⁶⁴ When evaluating
 14 production quotas, the DEA was instructed to consider the following information:

- 15 a. Information provided by the Department of Health and Human Services;
- 16 b. Total net disposal of the basic class by all manufacturers;
- 17 c. Trends in the national rate of disposal of the basic class;
- 18 d. An applicant’s production cycle and current inventory position;

19
 20 https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf.

21
 22 ⁴⁶¹ See Statement of Joseph T. Rannazzisi before the Caucus on International
 23 Narcotics Control United States Senate, July 18, 2012 (available at
 24 <https://www.justice.gov/sites/default/files/testimonies/witnesses/attachments/07/18/12/07-18-12-dea-rannazzisi.pdf>).

25 ⁴⁶² Id.

26 ⁴⁶³ Joseph T. Rannazzisi Decl. ¶ 10, *Cardinal Health, Inc. v. Eric Holder, Jr., Attorney General*, D.D.C. Case No. 12-cv-185 (Document 14-2 February 10, 2012).

27 ⁴⁶⁴ 1970 U.S.C.C.A.N. 4566 at 5490; *see also* Testimony of Joseph T. Rannazzisi
 28 before the Caucus on International Narcotics Control, United States Senate, May 5, 2015 (available at
https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf).

1 e. Total actual or estimated inventories of the class and of all substances
 2 manufactured from the class and trends in inventory accumulation; and
 3 g. Other factors such as: changes in the currently accepted medical use of
 4 substances manufactured for a basic class; the economic and physical
 5 availability of raw materials; yield and sustainability issues; potential
 6 disruptions to production; and unforeseen emergencies.⁴⁶⁵

7 644. It is unlawful for a registrant to manufacture a controlled substance in
 8 Schedule II, like prescription opioids, that is (1) not expressly authorized by its
 9 registration and by a quota assigned to it by DEA, or (2) in excess of a quota
 10 assigned to it by the DEA.⁴⁶⁶

11 645. At all relevant times, the RICO Diversion Defendants operated as an
 12 association-in-fact enterprise formed for the purpose of unlawfully increasing
 13 sales, revenues and profits by fraudulently increasing the quotas set by the DEA
 14 that would allow them to collectively benefit from a greater pool of prescription
 15 opioids to manufacture and distribute. In support of this common purpose and
 16 fraudulent scheme, the RICO Diversion Defendants jointly agreed to disregard
 17 their statutory duties to identify, investigate, halt and report suspicious orders of
 18 opioids and diversion of their drugs into the illicit market so that those orders
 19 would not result in a decrease, or prevent an increase in, the necessary quotas.
 20 The RICO Diversion Defendants conducted their pattern of racketeering activity
 21 in this jurisdiction and throughout the United States through this enterprise.

22 646. The opioid epidemic has its origins in the mid-1990s when, between
 23 1997 and 2007, per capita purchase of methadone, hydrocodone, and oxycodone
 24 increased 13-fold, 4-fold, and 9-fold, respectively. By 2010, enough prescription

25
 26 ⁴⁶⁵ See Testimony of Joseph T. Rannazzisi before the Caucus on International
 27 Narcotics Control, United State Senate, May 5, 2015 (available at
 28 https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf).

⁴⁶⁶ *Id.* (citing 21 U.S.C. 842(b)).

1 opioids were sold in the United States to medicate every adult in the country with
 2 a dose of 5 milligrams of hydrocodone every 4 hours for 1 month.⁴⁶⁷ On
 3 information and belief, the Opioid Diversion Enterprise has been ongoing for at
 4 least the last decade.⁴⁶⁸

5 647. The Opioid Diversion Enterprise was and is a shockingly successful
 6 endeavor. The Opioid Diversion Enterprise has been conducting business
 7 uninterrupted since its genesis. However, it was not until recently that federal and
 8 state regulators finally began to unravel the extent of the enterprise and the toll
 9 that it exacted on the American public.

10 648. At all relevant times, the Opioid Diversion Enterprise: (a) had an
 11 existence separate and distinct from each RICO Diversion Defendant; (b) was
 12 separate and distinct from the pattern of racketeering in which the RICO
 13 Diversion Defendants engaged; (c) was an ongoing and continuing organization
 14 consisting of legal entities, including each of the RICO Diversion Defendants; (d)
 15 was characterized by interpersonal relationships among the RICO Diversion
 16 Defendants; (e) had sufficient longevity for the enterprise to pursue its purpose;
 17 and (f) functioned as a continuing unit.. Each member of the Opioid Diversion
 18 Enterprise participated in the conduct of the enterprise, including patterns of
 19 racketeering activity, and shared in the astounding growth of profits supplied by
 20 fraudulently inflating opioid quotas and resulting sales.

21 649. The Opioid Diversion Enterprise also engaged in efforts to constrain
 22 the DEA's authority to hold the RICO Diversion Defendants liable for
 23 disregarding their duty to prevent diversion. Members of the Pain Care Forum
 24

25 ⁴⁶⁷ Keyes KM, Cerdá M, Brady JE, Havens JR, Galea S. Understanding the rural-
 26 urban differences in nonmedical prescription opioid use and abuse in the United
 27 States. Am J Public Health. 2014;104(2):e52-9.

28 ⁴⁶⁸ Matthew Perrone, [Pro-Painkiller echo chamber shaped policy amid drug epidemic](#), The Center for Public Integrity (September 19, 2017, 12:01 a.m.), <https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic>.

1 (described in greater detail below) and the Healthcare Distribution Alliance
 2 lobbied for the passage of legislation to weaken the DEA's enforcement authority.
 3 To this end, the Ensuring Patient Access and Effective Drug Enforcement Act
 4 significantly reduced the DEA's ability to issue orders to show cause and to
 5 suspend and/or revoke registrations.⁴⁶⁹ The HDA and other members of the Pain
 6 Care Forum contributed substantial amounts of money to political campaigns for
 7 federal candidates, state candidates, political action committees and political
 8 parties. Upon information and belief, the Pain Care Forum and its members and
 9 HDA, poured millions into such efforts.

10 650. The RICO Diversion Defendants, through their illegal enterprise,
 11 engaged in a pattern of racketeering activity that involves a fraudulent scheme to
 12 profit from the unlawful sale of prescription opioids by increasing the quotas
 13 governing the manufacture and sale of these controlled substances. In order to
 14 achieve that goal, the RICO Diversion Defendants knowingly allowed suspicious
 15 orders of controlled substances to occur unhindered while millions of opioid doses
 16 diverted into illegal markets. The end result of this strategy was exactly as the
 17 RICO Diversion Defendants intended – artificially increased quotas for the
 18 manufacture and distribution of opioids, all of which resulted in a National opioid
 19 epidemic.

20

21 ⁴⁶⁹ See HDMA is now the Healthcare Distribution Alliance, Pharmaceutical
 22 Commerce, (June 13, 2016, updated July 6, 2016),
<http://pharmaceuticalcommerce.com/business-and-finance/hdma-now-healthcare-distribution-alliance/>; Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html; Lenny Bernstein & Scott Higham, *Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017, https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html; Eric Eyre, *DEA Agent: "We Had no Leadership" in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017, <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1 651. The Opioid Diversion Enterprise engaged in, and its activities
2 affected, interstate and foreign commerce because the enterprise involved
3 commercial activities across states lines, such as manufacture, sale, distribution,
4 and shipment of prescription opioids throughout the United States, and the
5 corresponding payment and/or receipt of money from such interstate sales.

6 652. Within the Opioid Diversion Enterprise, there were interpersonal
7 relationships and common communication by which the RICO Diversion
8 Defendants shared information on a regular basis. These interpersonal
9 relationships also formed the organization of the Opioid Diversion Enterprise.
10 The Opioid Diversion Enterprise used their interpersonal relationships and
11 communication network for the purpose of conducting the enterprise through a
12 pattern of racketeering activity.

13 653. Each of the RICO Diversion Defendants had systematic links to each
14 other through joint participation in trade industry organizations, contractual
15 relationships and continuing coordination of activities. The RICO Diversion
16 Defendants participated in the operation and management of the Opioid Diversion
17 Enterprise by directing its affairs, as described herein. While the RICO Diversion
18 Defendants participated in, and are members of, the enterprise, they each have a
19 separate existence from the enterprise, including distinct legal statuses, different
20 offices and roles, bank accounts, officers, directors, employees, individual
21 personhood, reporting requirements, and financial statements.

22 654. The RICO Diversion Defendants exerted substantial control over the
23 Opioid Diversion Enterprise through their membership in the Pain Care Forum,
24 the HDA, and through their contractual relationships.

25 655. The Pain Care Forum (“PCF”) has been described as a coalition of
26 drug makers, trade groups and dozens of non-profit organizations supported by
27 industry funding. The PCF recently became a national news story when it was
28

1 discovered that lobbyists for members of the PCF quietly shaped federal and state
 2 policies regarding the use of prescription opioids for more than a decade.

3 656. The Center for Public Integrity and The Associated Press obtained
 4 “internal documents shed[ding] new light on how drug makers and their allies
 5 shaped the national response to the ongoing wave of prescription opioid abuse.”⁴⁷⁰
 6 Specifically, PCF members spent over \$740 million lobbying in the nation’s
 7 capital and in all 50 statehouses on an array of issues, including opioid-related
 8 measures.⁴⁷¹

9 657. Not surprisingly, each of the RICO Diversion Defendants who stood
 10 to profit from expanded prescription opioid use is a member of and/or participant
 11 in the PCF.⁴⁷² In 2012, membership and participating organizations included the
 12 HDA (of which all RICO Defendants are members), Endo, Purdue, Actavis (i.e.,
 13 Allergan), and Teva (the parent company of Cephalon).⁴⁷³ Each of the
 14 Manufacturer Defendants worked together through the PCF to advance the
 15 interests of the enterprise. But, the Manufacturer Defendants were not alone. The
 16 Distributor Defendants actively participated, and continue to participate in the
 17 PCF, at a minimum, through their trade organization, the HDA.⁴⁷⁴ Upon
 18

19 ⁴⁷⁰ Matthew Perrone, Pro-Painkiller echo chamber shaped policy amid drug
 20 epidemic, The Center for Public Integrity (September 19, 2017, 12:01 a.m.),
 21 <https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic> (emphasis added).

22 ⁴⁷¹ *Id.*

23 ⁴⁷² PAIN CARE FORUM 2012 Meetings Schedule, (last updated December 2011),
 24 <https://assets.documentcloud.org/documents/3108982/PAIN-CARE-FORUM-Meetings-Schedule-amp.pdf>

25 ⁴⁷³ *Id.* Upon information and belief, Mallinckrodt became an active member of the
 26 PCF sometime after 2012.

27 ⁴⁷⁴ *Id.* The Executive Committee of the HDA (formerly the HDMA) currently
 28 includes the Chief Executive Officer, Pharmaceutical Segment for Cardinal Health,
 Inc., the Group President, Pharmaceutical Distribution and Strategic Global Source
 for AmerisourceBergen Corporation, and the President, U.S. Pharmaceutical for
 McKesson Corporation. Executive Committee, Healthcare Distribution Alliance
 (accessed on September 14, 2017),
<https://www.healthcaredistribution.org/about/executive-committee>.

1 information and belief, the Distributor Defendants participated directly in the PCF
 2 as well.

3 658. Additionally, the HDA – or Healthcare Distribution Alliance – led to
 4 the formation of interpersonal relationships and an organization between the
 5 RICO Diversion Defendants. Although the entire HDA membership directory is
 6 private, the HDA website confirms that each of the Distributor Defendants and the
 7 Manufacturer Defendants named in the Complaint, including Actavis (i.e.,
 8 Allergan), Endo, Purdue, Mallinckrodt and Cephalon were members of the
 9 HDA.⁴⁷⁵ Additionally, the HDA and each of the Distributor Defendants, eagerly
 10 sought the active membership and participation of the Manufacturer Defendants
 11 by advocating for the many benefits of members, including “**strengthening . . .**
 12 **alliances.**”⁴⁷⁶

13 659. Beyond strengthening alliances, the benefits of HDA membership
 14 included the ability to, among other things, “network one on one with
 15 manufacturer executives at HDA’s members-only Business and Leadership
 16 Conference,” “networking with HDA wholesale distributor members,”
 17 “opportunities to host and sponsor HDA Board of Directors events,” “participate
 18 on HDA committees, task forces and working groups with peers and trading
 19 partners,” and “make connections.”⁴⁷⁷ Clearly, the HDA and the Distributor
 20 Defendants believed that membership in the HDA was an opportunity to create
 21 interpersonal and ongoing organizational relationships and “alliances” between
 22 the Manufacturers and Defendants.

23

24

⁴⁷⁵ **Manufacturer Membership**, Healthcare Distribution Alliance, (accessed on
 25 September 14, 2017),
<https://www.healthcaredistribution.org/about/membership/manufacturer>.

26

⁴⁷⁶ **Manufacturer Membership Benefits**, Healthcare Distribution Alliance, (accessed
 27 on September 14, 2017),
<https://www.healthcaredistribution.org/~/media/pdfs/membership/manufacturer-membership-benefits.ashx?la=en>.

28

⁴⁷⁷ *Id.*

1 660. The application for manufacturer membership in the HDA further
 2 indicates the level of connection between the RICO Defendants and the level of
 3 insight that they had into each other's businesses.⁴⁷⁸ For example, the
 4 manufacturer membership application must be signed by a "senior company
 5 executive," and it requests that the manufacturer applicant identify a key contact
 6 and any additional contacts from within its company.

7 661. The HDA application also requests that the manufacturer identify its
 8 current distribution information, including the facility name and contact
 9 information.

10 662. And, Manufacturer Members were asked to identify their "most
 11 recent year end net sales" through wholesale distributors, including the Distributor
 12 Defendants AmerisourceBergen, Cardinal Health, and McKesson and their
 13 subsidiaries.

14 663. The closed meetings of the HDA's councils, committees, task forces
 15 and working groups provided the Manufacturer and Distributor Defendants with
 16 the opportunity to work closely together, confidentially, to develop and further the
 17 common purpose and interests of the enterprise.

18 664. The HDA also offers a multitude of conferences, including annual
 19 business and leadership conferences. The HDA, and the Distributor Defendants
 20 advertise these conferences to the Manufacturer Defendants as an opportunity to
 21 "bring together high-level executives, thought leaders and influential managers . .
 22 . to hold strategic business discussions on the most pressing industry issues."⁴⁷⁹

24 478 Manufacturer Membership Application, Healthcare Distribution Alliance,
 25 (accessed on September 14, 2017),
<https://www.healthcaredistribution.org/~media/pdfs/membership/manufacturer-membership-application.ashx?la=en>.

26 479 Business and Leadership Conference – Information for Manufacturers,
 27 Healthcare Distribution
 28 Alliance <https://www.healthcaredistribution.org/events/2015-business-and-leadership-conference/blc-for-manufacturers> (last accessed on September 14, 2017).

1 The conferences also gave the Manufacturer and Distributor Defendants
 2 “unmatched opportunities to network with [their] peers and trading partners at all
 3 levels of the healthcare distribution industry.”⁴⁸⁰ The HDA and its conferences
 4 were significant opportunities for the Manufacturer and Distributor Defendants to
 5 interact at a high-level of leadership. It is clear that the Manufacturer Defendants
 6 embraced this opportunity by attending and sponsoring these events.⁴⁸¹

7 665. Third, the RICO Diversion Defendants maintained their interpersonal
 8 relationships by working together, through contractual chargeback arrangements,
 9 to exchanging sales information and drive the unlawful sales of their opioids. To
 10 this end, the Manufacturer Defendants engaged in an industry-wide practice of
 11 paying rebates to the Distributor Defendants for sales of prescription opioids.⁴⁸²

12 666. For example, the *Washington Post* reported that “[o]n Aug. 23, 2011,
 13 DEA supervisors met with Mallinckrodt executives at the agency’s headquarters
 14 in Arlington, Va., the day a rare 5.8-magnitude earthquake hit the Washington
 15 region. People involved in the case still call the gathering ‘the earthquake
 16 meeting.’ DEA officials showed the company the remarkable amounts of its
 17 oxycodone going to distributors and the number of arrests being made for
 18 oxycodone possession and distribution on the street, according to one participant

19
 20 ⁴⁸⁰ *Id.*
 21 ⁴⁸¹ 2015 Distribution Management Conference and Expo, Healthcare Distribution
 22 Alliance, <https://www.healthcaredistribution.org/events/2015-distribution-management-conference> (last accessed on September 14, 2017).

23 ⁴⁸² Lenny Bernstein & Scott Higham, The government’s struggle to hold opioid
 24 manufacturers accountable, The Washington Post, (April 2, 2017),
https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm_term=.b24cc81cc356; *see also*, Letter from Sen. Claire
 25 McCaskill, (July 27, 2017),
<https://www.mccaskill.senate.gov/imo/media/image/july-opioid-investigation-letter-manufacturers.png>; Letter from Sen. Claire McCaskill, (July 27, 2017),
<https://www.mccaskill.senate.gov/imo/media/image/july-opioid-investigation-letter-manufacturers.png>; Letters From Sen. Claire McCaskill, (March 28, 2017),
<https://www.mccaskill.senate.gov/opioid-investigation>; Purdue Managed Markets,
 26 Purdue Pharma, (accessed on September 14, 2017),
<http://www.purduepharma.com/payers/managed-markets/>.

1 in the meeting who also spoke on the condition of anonymity because the case is
2 pending.”⁴⁸³

3 667. “Three weeks after the Aug. 23 meeting, Mallinckrodt notified 43 of
4 its distributors that they would no longer receive rebates from the company if they
5 continued to supply certain pharmacies whose orders appeared to be
6 suspicious.”⁴⁸⁴

7 668. “On Nov. 30, 2011, the DEA served a subpoena on Mallinckrodt,
8 demanding documents related to its suspicious-order-monitoring program,
9 according to the company’s filings with the Securities and Exchange Commission.
10 The subpoena brought a windfall of information. The DEA gained access to data
11 from Mallinckrodt’s rebate or ‘chargeback’ program, an industry-wide practice
12 that provides reimbursements to wholesale distributors. That information and
13 other records showed where Mallinckrodt’s oxycodone was going — from the
14 company to its network of distributors to retailers down the chain.”⁴⁸⁵

15 669. In addition, the Distributor Defendants and Manufacturer Defendants
16 participated, through the HDA, in Webinars and other meetings designed to
17 exchange detailed information regarding their prescription opioid sales, including
18 purchase orders, acknowledgements, ship notices, and invoices.⁴⁸⁶ For example,
19 on April 27, 2011, the HDA offered a Webinar to “accurately and effectively
20 exchange business transactions between distributors and manufacturers...”:

21

22

23

24

⁴⁸³ https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm_term=.f336835fd5da

25

26

27

28

⁴⁸⁴ Id.

⁴⁸⁵ Id.

⁴⁸⁶ Webinars, Healthcare Distribution Alliance, (accessed on September 14, 2017), <https://www.healthcaredistribution.org/resources/webinar-leveraging-edi>.

1 Webinar Leveraging EDI: Order-to-Cash 2 Transactions CD Box Set



3 (Webinar held: April 27, 2011) Using EDI to
4 accurately and efficiently exchange business
5 transactions (i.e., purchase orders,
6 acknowledgements, ship notices, invoices, etc.)
7 between distributors and manufacturers in the
8 healthcare supply chain is critical. The
9 development and use of voluntary guidelines
for specific EDI standards provide industry

10 trading partners with a means to effectively convey the necessary information.

11 Hear updates on HDMA's Order-to-Cash Guidelines for Electronic Data Interchange (EDI) in the
12 Healthcare Product Supply Chain, including the 810 Invoice; 850 Purchase Order; 855 Purchase
Order Acknowledgement; and the 856 Ship Notice/Manifest.

13 670. On information and belief, the Manufacturer Defendants used this
14 information to gather high-level data regarding overall distribution and direct the
15 Distributor Defendants on how to most effectively sell the prescription opioids.

16 671. And, through the HDA, Manufacturer Members were asked to
17 identify their "most recent year end net sales" through wholesale distributors,
18 including the Distributor Defendants as follows:

Company	Most Recent Year End Net Sales
Henry Schein, Inc. Henry Schein Distribution Centers (7)	
Hospital Pharmaceutical Consulting (1)	
KeySource Medical, Inc. (1)	
Louisiana Wholesale Drug Co. Inc. (1)	
McKesson Corporation (71) McKesson Supply Solutions (25) McKesson Canada (12) McKesson Corporation (4) McKesson Specialty Health (1) McKesson Strategic Redistribution Center (1) McKesson Medical Surgical (1) Physician Sales & Service (PSS) (25) US Oncology (1) DeVictoria Healthcare, Inc. PR (1)	
Miami-Lukan, Inc. (1)	
Morris & Dickson Co., LLC (1)	
Mutual Wholesale Drug Co. (1)	
PBA Health (1)	
Prescription Supply, Inc. (1)	
Prodigy Health Supplier Corporation (1)	
Quality Care Products, LLC (1)	
RDC (3)	
R&S Northeast LLC (2)	
Richie Pharmaceutical Co., LLC (1)	
Seacoast Medical LLC (1)	
Smith Drug Company, Div. J.M. Smith Corporation (4) Burlington Drug Company, Inc. (1) Smith Drug Company, Div. J.M. Smith Corporation (3)	
Top Rx (4)	
Value Drug Company (1)	
VaxServe (1)	
TOTAL SALES (millions)	
\$ 0	

1 672. The contractual relationships among the RICO Defendants also
 2 include vault security programs. The RICO Diversion Defendants are required to
 3 maintain certain security protocols and storage facilities for the manufacture and
 4 distribution of their opiates. Upon information and belief, the manufacturers
 5 negotiated agreements whereby the Manufacturers installed security vaults for
 6 Distributors in exchange for agreements to maintain minimum sales performance
 7 thresholds. Upon information and belief, these agreements were used by the
 8 RICO Diversion Defendants as a tool to violate their reporting and diversion
 9 duties in order to reach the required sales requirements.

10 673. Taken together, the interaction and length of the relationships
 11 between and among the Manufacturer and Distributor Defendants reflects a deep
 12 level of interaction and cooperation between two groups in a tightly knit industry.
 13 The Manufacturer and Distributor Defendants were not two separate groups
 14 operating in isolation or two groups forced to work together in a closed system.
 15 The RICO Diversion Defendants operated together as a united entity, working
 16 together on multiple fronts, to engage in the unlawful sale of prescription opioids.
 17 The HDA and the Pain Care Forum are but two examples of the overlapping
 18 relationships, and concerted joint efforts to accomplish common goals and
 19 demonstrates that the leaders of each of the RICO Diversion Defendants were in
 20 communication and cooperation.

21 674. Alternatively, the RICO Diversion Defendants were members of a
 22 legal entity enterprise within the meaning of 18 U.S.C. § 1961(4), through which
 23 the RICO Diversion Defendants conducted their pattern of racketeering activity in
 24 this jurisdiction and throughout the United States. As alleged, the Healthcare
 25 Distribution Alliance (the “HDA”)⁴⁸⁷ is a distinct legal entity that satisfies the
 26

27 28 ⁴⁸⁷ Health Distribution Alliance, [History](#), Health Distribution Alliance, (last
 accessed on September 15, 2017),
<https://www.healthcaredistribution.org/about/hda-history>.

1 definition of a RICO enterprise because it is a corporation formed under the laws
2 of the District of Columbia, doing business in Virginia. As such, the HDA
3 qualifies as an “enterprise” within the definition set out in 18 U.S.C. § 1961(4).

4 675. On information and belief, each of the RICO Diversion Defendants is
5 a member, participant, and/or sponsor of the HDA, and has been since at least
6 2006, and utilized the HDA to conduct the Opioid Diversion Enterprise and to
7 engage in the pattern of racketeering activity that gives rise to the Count.

8 676. Each of the RICO Diversion Defendants is a legal entity separate and
9 distinct from the HDA. Additionally, the HDA serves the interests of distributors
10 and manufacturers beyond the RICO Diversion Defendants. Therefore, the HDA
11 exists separately from the Opioid Diversion Enterprise, and each of the RICO
12 Diversion Defendants exists separately from the HDA. Therefore, the HDA may
13 serve as a RICO enterprise.

14 **B. CONDUCT OF THE OPIOID DIVERSION ENTERPRISE.**

15 677. During the time period alleged in this Complaint, the RICO
16 Diversion Defendants exerted control over, conducted and/or participated in the
17 Opioid Diversion Enterprise by fraudulently claiming that they were complying
18 with their duties under the CSA to identify, investigate and report suspicious
19 orders of opioids in order to prevent diversion of those highly addictive substances
20 into the illicit market, and to halt such unlawful sales, so as to increase production
21 quotas and generate unlawful profits, as follows:

22 678. Defendants disseminated false and misleading statements to state and
23 federal regulators claiming that (1) the quotas for prescription opioids should be
24 increased, (2) they were complying with their obligations to maintain effective
25 controls against diversion of their prescription opioids, (3) they were complying
26 with their obligations to design and operate a system to disclose to the registrant
27 suspicious orders of their prescription opioids, (4) they were complying with their
28 obligation to notify the DEA of any suspicious orders or diversion of their

1 prescription opioids and (5) they did not have the capability to identify suspicious
 2 orders of controlled substances despite their possession of national, regional, state,
 3 and local prescriber- and patient-level data that allowed them to track prescribing
 4 patterns over time, which the Defendants obtained from data companies, including
 5 but not limited to: IMS Health, QuintilesIMS, Iqvia, Pharmaceutical Data
 6 Services, Source Healthcare Analytics, NDS Health Information Services,
 7 Verispan, Quintiles, SDI Health, ArcLight, Scriptline, Wolters Kluwer, and/or
 8 PRA Health Science, and all of their predecessors or successors in interest (the
 9 “Data Vendors”).

10 679. The RICO Diversion Defendants applied political and other pressure
 11 on the DOJ and DEA to halt prosecutions for failure to report suspicious orders of
 12 prescription opioids and lobbied Congress to strip the DEA of its ability to
 13 immediately suspend registrations pending investigation by passing the “Ensuring
 14 Patient Access and Effective Drug Enforcement Act.”⁴⁸⁸

15 680. The Distributor Defendants developed “know your customer”
 16 questionnaires and files. This information, compiled pursuant to comments from
 17 the DEA in 2006 and 2007 was intended to help the RICO Diversion Defendants
 18 identify suspicious orders or customers who were likely to divert prescription
 19
 20

21 ⁴⁸⁸ See HDMA is now the Healthcare Distribution Alliance, Pharmaceutical
 22 Commerce, (June 13, 2016, updated July 6, 2016),
<http://pharmaceuticalcommerce.com/business-and-finance/hdma-now-healthcare-distribution-alliance/>; Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html; Lenny Bernstein & Scott Higham, *Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017, https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html; Eric Eyre, *DEA Agent: “We Had no Leadership” in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017, <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1 opioids.⁴⁸⁹ On information and belief, the “know your customer” questionnaires
 2 informed the RICO Diversion Defendants of the number of pills that the
 3 pharmacies sold, how many non-controlled substances are sold compared to
 4 controlled substances, whether the pharmacy buys from other distributors, the
 5 types of medical providers in the area, including pain clinics, general practitioners,
 6 hospice facilities, cancer treatment facilities, among others, and these
 7 questionnaires put the recipients on notice of suspicious orders.

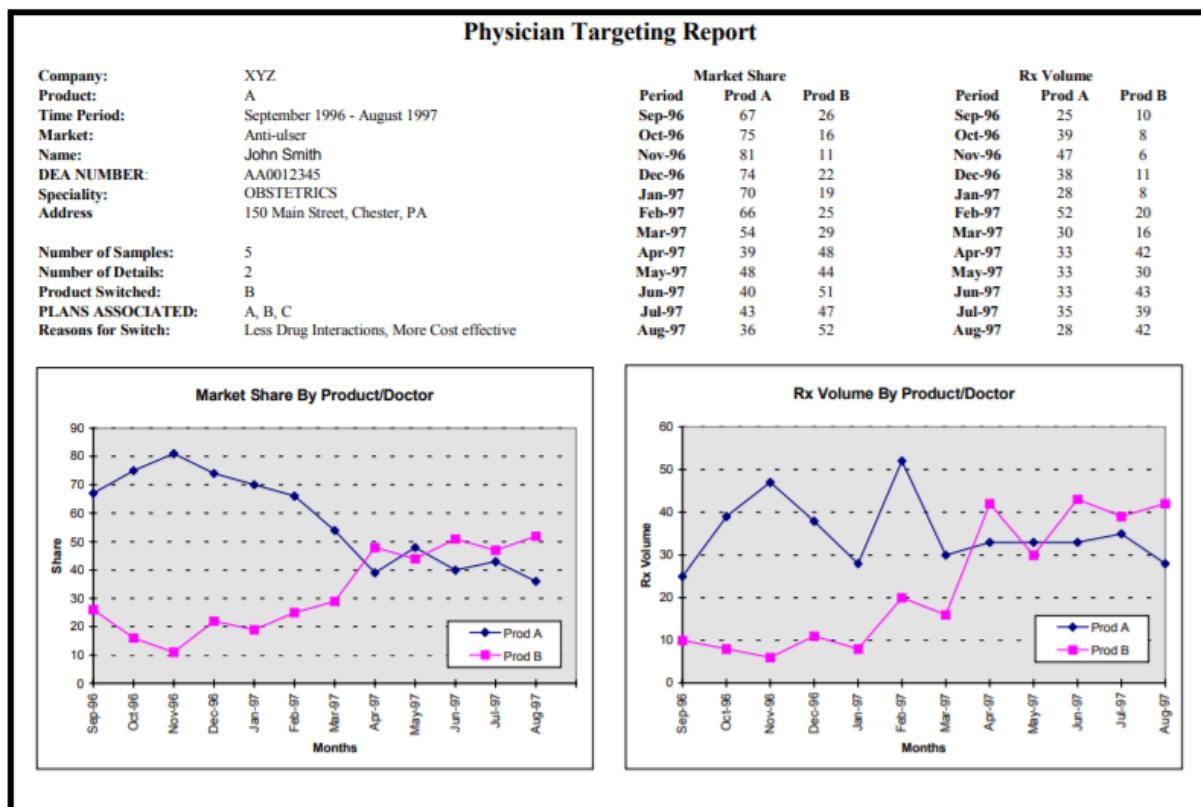
8 681. The RICO Diversion Defendants purchased nationwide, regional,
 9 state, and local prescriber- and patient-level data from the Data Vendors that
 10 allowed them to track prescribing trends, identify suspicious orders, identify
 11 patients who were doctor shopping, identify pill mills, etc. The Data Vendors’
 12 information purchased by the RICO Diversion Defendants allowed them to view,
 13 analyze, compute, and track their competitors sales, and to compare and analyze
 14 market share information.⁴⁹⁰

15 682. IMS, for example, IMS provided the RICO Diversion Defendants
 16 with reports detailing prescriber behavior and the number of prescriptions written
 17 between competing products.⁴⁹¹
 18
 19
 20

21 ⁴⁸⁹ Suggested Questions a Distributor should ask prior to shipping controlled
 22 substances, Drug Enforcement Administration (available at
https://www.deadiversion.usdoj.gov/mtgs/pharm_industry/14th_pharm/levin1 ques.pdf); Richard Widup, Jr., Kathleen H. Dooley, Esq. Pharmaceutical Production
Diversion: Beyond the PDMA, Purdue Pharma and McGuireWoods LLC,
 (available at https://www.mcguirewoods.com/news-resources/publications/lifesciences/product_diversion_beyond_pdma.pdf).

23
 24
 25 ⁴⁹⁰ A Verispan representative testified that the RICO Defendants use the
 26 prescribing information to “drive market share.” *Sorrell v. IMS Health Inc.*, 2011
 27 WL 661712, *9-10 (Feb. 22, 2011).

28 ⁴⁹¹ Paul Kallukaran & Jerry Kagan, *Data Mining at IMS HEALTH: How we Turned*
 29 *a Mountain of Data into a Few Information-rich Molehills*, (accessed on February
 30 15, 2018),
<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.198.349&rep=rep1&type=pdf>, Figure 2 at p.3.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
Figure 2:

683. Similarly, Wolters Kluwer, an entity that eventually owned data mining companies that were created by McKesson (Source) and Cardinal Health (ArcLight), provided the RICO Defendants with charts analyzing the weekly prescribing patterns of multiple physicians, organized by territory, regarding competing drugs, and analyzed the market share of those drugs.⁴⁹²

⁴⁹² *Sorrell v. IMS Health Inc.*, 2011 WL 705207, *467-471 (Feb. 22, 2011).

1. The Prescriber Roster shows Prescriber demographics, prescribing information and indicator arrows

Territory : 1102		Weekly Prescriber TR					
Prescriber	Trend	Specialty	Product	WEEK Feb-03-06	WEEK Jan-27-06	WEEK Jan-20-06	WEEK Jan-13-06
Territory : 1102 – TOTAL			PRODUCT A	46	64	58	88
			PRODUCT B	292	253	247	278
			PRODUCT C	55	56	56	58
			PRODUCT D	36	28	34	33
			PRODUCT E	7	9	2	9
			PRODUCT F	1	3	5	0
Doctor A		IM	PRODUCT A	4	1	1	1
			PRODUCT B	2	2	2	3
			PRODUCT C	0	2	0	0
			PRODUCT D	0	0	0	0
			PRODUCT E	0	0	0	0
			PRODUCT F	0	0	0	0
Doctor B		GE	PRODUCT A	3	1	1	2
			PRODUCT B	5	4	7	2
			PRODUCT C	0	1	0	0
			PRODUCT D	0	0	0	0
			PRODUCT E	0	1	0	1
			PRODUCT F	0	0	0	0
Doctor C		GE	PRODUCT A	3	1	2	0
			PRODUCT B	4	5	0	3
			PRODUCT C	0	1	1	0
			PRODUCT D	0	1	0	2
			PRODUCT E	0	0	0	0
			PRODUCT F	0	0	0	0

卷六

3. Territory Summary Report shows Prescriber Roster information aggregated at a territory level

Territory Summary

Name	Spec	Zip	Product A NRX	Product A MM Share	Product A Rank	Market NRX	Market Rank
ABNEY, RAY C.	P	05302	6	10.7%	43	56	38
ALLISTER, ROBERT	P	03820	6	18.8%	43	32	63
ALTMAN, LEE S.	P	01655	34	14.0%	3	247	3
BALLARD, HARLOW	P	05801	0	0.0%	93	8	96
BARNEY, CHRISTINE A.	P	03766	6	26.1%	43	23	85
BARTON, GAIL	P	03755	13	32.5%	18	40	50
BERNSTEIN, RICHARD A.	P	05401	0	0.0%	93	14	94
BOHNERI, MICHAEL	P	03060	3	4.5%	73	66	29
BOSTIC, JEFFERY O.	CHP	03079	5	10.9%	55	45	44
BREITHOLTZ, TIMOTHY	P	03870	13	34.2%	18	38	52
BROWN, KENNETH	P	03941	4	10.0%	61	40	50
BUCHANAN, KEVIN	P	05701	5	16.1%	55	31	70
CARMAN, MEGAN W.	P	03246	10	12.3%	28	81	18
CARSEN, MARJORIA	P	05701	6	18.2%	43	33	59
CATPANO-FRIEDMAN, LISA	P	05201	5	8.6%	43	70	25
CLARKE-RUBIN, LORNA	P	12901	8	24.2%	32	33	59
COHEN, DEVRA H.	CHP	03060	3	6.5%	73	46	44
COLE, STEPHEN A.	P	05101	5	13.2%	55	38	52
COTTON, PAUL G.	P	05401	13	28.3%	18	46	44
CUSI, PRISCILLA M.	P	03104	17	7.9%	14	215	5
DAVISON, MARTHA F.	P	03110	14	11.3%	16	124	8
DEJONG, JACOB	P	03067	0	0.0%	93	21	87
DELFAUSSE, PETER O.	P	03301	6	35.3%	43	17	90
DENNETT, DOUGLAS E.	CHP	05401	0	0.0%	93	33	59
DEPPE, SUSAN L.	P	05401	1	0.3%	87	300	2
DEVENDERRAO, T.	P	03060	7	9.6%	37	73	21

684. This information allowed the RICO Diversion Defendants to track and identify instances of, overprescribing.⁴⁹³ In fact, one of the Data Venders' experts testified that a manufacturer of "narcotic analgesics" used the Data Venders' information to track, identify, report and halt suspicious orders of controlled substances.⁴⁹⁴

⁴⁹³ See *Sorrell v. IMS Health Inc.*, 2011 WL 1449043, *37-38 (March 24, 2011) (arguing that data had been used to “identify overuse of antibiotics in children,” and “whether there is a wide use of anthrax prophylactic medicines after the scares happened in 2001.”). The Data Vender Respondents also cited evidence from the trial court proving that “because analysis of PI data makes it possible to ‘identify overuse of a pharmaceutical in specific conditions, the government employs the data to monitor usage of controlled substances.’” *Id.*

⁴⁹⁴ *Id.* at *38. Eugene "Mick" Kolassa testified as an expert on behalf of the Data Vender stating that "a firm that sells narcotic analgesics was able to use prescriber-identifiable information to identify physicians that seemed to be prescribing an

1 [455] Q. Besides marketing and promotion, are
2 there any other uses for prescriber-identifiable data?

3 A. There's a number of other uses.

4 Q. And what are those?

5 A. The one that I was most impressed with
6 was a firm that used it to identify - a firm that
7 sells narcotic analgesics was able to use prescriber-
8 identifiable information to identify physicians that
9 seemed to be prescribing an inordinately high num-
10 ber of prescriptions for their product and they would
11 use that to notify the DEA and other authorities of
12 potential problems.

13
14 685. The RICO Diversion Defendants were, therefore, collectively aware
15 of the suspicious orders that flowed daily from their manufacturing and
16 distribution facilities.

17 686. The RICO Diversion Defendants refused to identify, investigate and
18 report suspicious orders to the DEA when they became aware of the same despite
19 their actual knowledge of drug diversion rings. The RICO Diversion Defendants
20 refused to identify suspicious orders and diverted drugs despite the DEA issuing
21 final decisions against the Distributor Defendants in 178 registrant actions
22 between 2008 and 2012⁴⁹⁵ and 117 recommended decision in registrant actions
23 from The Office of Administrative Law Judges. These numbers include seventy-
24 six (76) actions involving orders to show cause and forty-one (41) actions

25
26 inordinately high number of prescriptions for their product." *Id*; see also Joint
27 Appendix in *Sorrell v. IMS Health*, 2011 WL 687134, at *204 (Feb. 22, 2011).

28 ⁴⁹⁵ Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep't of
Justice, *The Drug Enforcement Administration's Adjudication of Registrant Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 involving immediate suspension orders – all for failure to report suspicious
2 orders.⁴⁹⁶

3 687. Defendants' scheme had a decision-making structure driven by the
4 Manufacturer Defendants and corroborated by the Distributor Defendants. The
5 Manufacturer Defendants worked together to control the State and Federal
6 Government's response to the manufacture and distribution of prescription opioids
7 by increasing production quotas through a systematic refusal to maintain effective
8 controls against diversion, and identify suspicious orders and report them to the
9 DEA.

10 688. The RICO Diversion Defendants worked together to control the flow
11 of information and influence state and federal governments and political
12 candidates to pass legislation that was pro-opioid. The Manufacturer and
13 Distributor Defendants did this through their participation in the PCF and HDA.

14 689. The RICO Diversion Defendants also worked together to ensure that
15 the Aggregate Production Quotas, Individual Quotas and Procurement Quotas
16 allowed by the DEA remained artificially high and ensured that suspicious orders
17 were not reported to the DEA in order to ensure that the DEA had no basis for
18 refusing to increase or decrease production quotas due to diversion. The RICO
19 Diversion Defendants influenced the DEA production quotas in the following
20 ways:

21 690. The scheme devised and implemented by the RICO Diversion
22 Defendants amounted to a common course of conduct characterized by a refusal to
23 maintain effective controls against diversion, and all designed and operated to
24 ensure the continued unlawful sale of controlled substances.

25
26
27
28

⁴⁹⁶ Id.

1 **C. PATTERN OF RACKETEERING ACTIVITY.**

2 691. The RICO Diversion Defendants conducted and participated in the
3 conduct of the Opioid Diversion Enterprise through a pattern of racketeering
4 activity as defined in 18 U.S.C. § 1961(1)(D), including ; the felonious
5 manufacture, importation, receiving, concealment buying selling, or otherwise
6 dealing in a controlled substance or listed chemical (as defined in section 102 of
7 the Controlled Substance Act), punishable under any law of the United States; and
8 18 U.S.C. 1961(1)(B), including mail fraud (18 U.S.C. § 1341) and wire fraud (18
9 U.S.C. § 1343).

10 **1. The RICO Defendants Manufactured, Sold and/or Dealt
11 in Controlled Substances and Their Actions Constitute
12 Crimes Punishable as Felonies.**

13 692. The RICO Diversion Defendants conducted and participated in the
14 conduct of the affairs of the Opioid Diversion Enterprise through a pattern of
15 racketeering activity as defined in 18 U.S.C. § 1961(1)(D) by the felonious
16 manufacture, importation, receiving, concealment, buying, selling, or otherwise
17 dealing in a controlled substance or listed chemical (as defined in section 102 of
18 the Controlled Substance Act), punishable under any law of the United States.

19 693. The RICO Diversion Defendants committed crimes that are
20 punishable as felonies under the laws of the United States. Specifically, 21 U.S.C.
21 § 843(a)(4) makes it unlawful for any person to knowingly or intentionally furnish
22 false or fraudulent information in, or omit any material information from, any
23 application, report, record or other document required to be made, kept or filed
24 under this subchapter. A violation of section 843(a)(4) is punishable by up to four
25 years in jail, making it a felony. 21 U.S.C. § 843(d)(1).

26 694. Each of the RICO Diversion Defendants qualifies as a registrant
27 under the CSA. Their status as registrants under the CSA requires that they
28 maintain effective controls against diversion of controlled substances in schedule I

1 or II, design and operate a system to disclose to the registrant suspicious orders of
2 controlled substances and inform the DEA of suspicious orders when discovered
3 by the registrant. 21 U.S.C. § 823; 21 C.F.R. § 1301.74(b).

4 695. The CSA and the Code of Federal Regulations, require the RICO
5 Diversion Defendants to make reports to the DEA of any suspicious orders
6 identified through the design and operation of their system to disclose suspicious
7 orders. The failure to make reports as required by the CSA and Code of Federal
8 Regulations amounts to a criminal violation of the statute.

9 696. The RICO Diversion Defendants knowingly and intentionally
10 furnished false or fraudulent information in their reports to the DEA about
11 suspicious orders, and/or omitted material information from reports, records and
12 other document required to be filed with the DEA including the Manufacturer
13 Defendants' applications for production quotas. Specifically, the RICO Diversion
14 Defendants were aware of suspicious orders of prescription opioids and the
15 diversion of their prescription opioids into the illicit market, and failed to report
16 this information to the DEA in their mandatory reports and their applications for
17 production quotas.

18 697. Upon information and belief, the foregoing examples reflect the
19 RICO Diversion Defendants' pattern and practice of willfully and intentionally
20 omitting information from their mandatory reports to the DEA as required by 21
21 C.F.R. § 1301.74. The sheer volume of enforcement actions available in the
22 public record against the Distributor Defendants supports this conclusion.⁴⁹⁷ For
23 example:

24 698. On April 24, 2007, the DEA issued an *Order to Show Cause and*
25 *Immediate Suspension Order* against the AmerisourceBergen Orlando, Florida

27
28

⁴⁹⁷ Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep't of
Justice, *The Drug Enforcement Administration's Adjudication of Registrant Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 distribution center (“Orlando Facility”) alleging failure to maintain effective
2 controls against diversion of controlled substances. On June 22, 2007,
3 AmerisourceBergen entered into a settlement that resulted in the suspension of its
4 DEA registration.

5 699. On November 28, 2007, the DEA issued an *Order to Show Cause*
6 and *Immediate Suspension Order* against the Cardinal Health Auburn,
7 Washington Distribution Center (“Auburn Facility”) for failure to maintain
8 effective controls against diversion of hydrocodone.

9 700. On December 5, 2007, the DEA issued an *Order to Show Cause and*
10 *Immediate Suspension Order* against the Cardinal Health Lakeland, Florida
11 Distribution Center (“Lakeland Facility”) for failure to maintain effective controls
12 against diversion of hydrocodone.

13 701. On December 7, 2007, the DEA issued an *Order to Show Cause and*
14 *Immediate Suspension Order* against the Cardinal Health Swedesboro, New Jersey
15 Distribution Center (“Swedesboro Facility”) for failure to maintain effective controls
16 against diversion of hydrocodone.

17 702. On January 30, 2008, the DEA issued an *Order to Show Cause and*
18 *Immediate Suspension Order* against the Cardinal Health Stafford, Texas
19 Distribution Center (“Stafford Facility”) for failure to maintain effective controls
20 against diversion of hydrocodone.

21 703. On May 2, 2008, McKesson Corporation entered into an
22 *Administrative Memorandum of Agreement* (“2008 MOA”) with the DEA which
23 provided that McKesson would “maintain a compliance program designed to
24 detect and prevent the diversion of controlled substances, inform DEA of
25 suspicious orders required by 21 C.F.R. § 1301.74(b), and follow the procedures
26 established by its Controlled Substance Monitoring Program.”

27 704. On September 30, 2008, Cardinal Health entered into a *Settlement*
28 and *Release Agreement and Administrative Memorandum of Agreement* with the

1 DEA related to its Auburn Facility, Lakeland Facility, Swedesboro Facility and
2 Stafford Facility. The document also referenced allegations by the DEA that
3 Cardinal failed to maintain effective controls against the diversion of controlled
4 substances at its distribution facilities located in McDonough, Georgia
5 (“McDonough Facility”), Valencia, California (“Valencia Facility”) and Denver,
6 Colorado (“Denver Facility”).

7 705. On February 2, 2012, the DEA issued an *Order to Show Cause and*
8 *Immediate Suspension Order* against the Cardinal Health Lakeland, Florida
9 Distribution Center (“Lakeland Facility”) for failure to maintain effective controls
10 against diversion of oxycodone.

11 706. On May, 14, 2012, Cardinal Health entered into an Administrative
12 Memorandum of Agreement with the DEA in which, among other things,
13 Cardinal Health “admits that its due diligence efforts for some pharmacy
14 customers and its compliance with the 2008 MOA, in certain respects, were
15 inadequate.”

16 707. Thereafter, on December 23, 2016, Cardinal Health agreed to pay a
17 \$44 million fine to the DEA to resolve the civil penalty portion of the
18 administrative action taken against its Lakeland, Florida Distribution Center.

19 708. On January 5, 2017, McKesson Corporation entered into an
20 *Administrative Memorandum Agreement* with the DEA wherein it agreed to pay a
21 \$150,000,000 civil penalty for violation of the 2008 MOA as well as failure to
22 identify and report suspicious orders at its facilities in Aurora CO, Aurora IL,
23 Delran NJ, LaCrosse WI, Lakeland FL, Landover MD, La Vista NE, Livonia MI,
24 Methuen MA, Santa Fe Springs CA, Washington Courthouse OH and West
25 Sacramento CA.

26

27

28

1 709. In its Administrative Memorandum Agreement, McKesson
2 acknowledged its wrongdoing and failure to comply with the obligations imposed
3 by the CSA:

4 2. Acceptance of Responsibility. On or about September 27, 2006, February 7, 2007 and
5 December 27, 2007, DEA's Deputy Assistant Administrator, Office of Diversion Control, sent
6 letters to every entity in the United States that was registered with DEA to manufacture or
7 distribute controlled substances, including McKesson (the "DEA Letters"). The DEA Letters
8 contained, among other things, guidance for the identification and reporting of suspicious orders
9 to DEA, as required by 21 C.F.R. § 1301.74(b). McKesson acknowledges that, at various times
10 during the period from January 1, 2009 up through and including the Effective Date of this
11 Agreement (the "Covered Time Period"), it did not identify or report to DEA certain orders
12 placed by certain pharmacies which should have been detected by McKesson as suspicious based
13 on the guidance contained in the DEA Letters about the requirements set forth in 21 C.F.R. §
14 1301.74(b) and 21 U.S.C. § 842(a)(5). McKesson has taken steps to prevent such conduct from
15 occurring in the future, including the measures delineated in the Compliance Addendum.
16

17 On or about May 2, 2008, DEA and McKesson entered into an Administrative
18 Memorandum of Agreement (the "2008 MOA"). The 2008 MOA provided among other things,
19 that McKesson maintain a compliance program designed to detect and prevent the diversion of
20 controlled substances, inform DEA of suspicious orders as required by 21 C.F.R. § 1301.74(b),
21 and follow procedures established by its Controlled Substance Monitoring Program ("CSMP").
22 McKesson acknowledges that, at various times during the Covered Time Period, it did not
23 identify or report to DEA certain orders placed by certain pharmacies, which should have been
24 detected by McKesson as suspicious, in a manner fully consistent with the requirements set forth
25 in the 2008 MOA. McKesson has taken steps to prevent such conduct from occurring in the
26 future, including the measures delineated in the Compliance Addendum.

27 710. On April 23, 2015, McKesson filed a Form-8-K announcing a
28 settlement with the DEA and DOJ wherein it admitted to violating the CSA and
agreed to pay \$150 million and have some of its DEA registrations suspended on a
staggered basis.

29 711. In 2016, the Los Angeles Times reported that Purdue was aware of a
30 pill mill operating out of Los Angeles yet failed to alert the DEA. The LA Times
31 uncovered that Purdue began tracking a surge in prescriptions in Los Angeles,
32 including one prescriber in particular. Documents published by the L.A. Times
33 reveal that a Purdue sales manager spoke with company officials, asking:
34

35 712. Purdue was clearly aware of diversion. As a registrant, Purdue has
36 the same obligation to report suspicious orders as a wholesale distributor.
37 Although Purdue claimed that it was considering making a report to the DEA, it
38

1 shirked its responsibility, claimed that it was the wholesaler's responsibility and
2 then reserved the right to make the report:

3 713. Despite its knowledge of obvious diversion, "Purdue did not shut off
4 the supply of highly addictive OxyContin and did not tell authorities what it knew
5 about [a pill mill] until several years later when the clinic was out of business and
6 its leaders indicted. By that time, 1.1 million pills had spilled into the hands of
7 Armenian mobsters, the Crips gang and other criminals."

8 714. Finally, Mallinckrodt was recently the subject of a DEA and Senate
9 investigation for its opioid practices. Specifically, in 2011, the DEA targeted
10 Mallinckrodt arguing that it ignored its responsibility to report suspicious orders
11 as 500 million of its pills ended up in Florida between 2008 and 2012. After six
12 years of DEA investigation, Mallinckrodt agreed to a settlement involving a \$35
13 million fine. Federal prosecutors summarized the case by saying that
14 Mallinckrodt's response was that everyone knew what was going on in Florida but
15 they had no duty to report it.

16 715. These actions against the Distributor Defendants confirm that the
17 Distributor Defendants knew they had a duty to maintain effective controls against
18 diversion, design and operate a system to disclose suspicious orders, and to report
19 suspicious orders to the DEA. These actions also demonstrate, on information and
20 belief, that the Manufacturer Defendants were aware of the enforcement against
21 their Distributors and the diversion of the prescription opioids and a
22 corresponding duty to report suspicious orders.

23 716. The pattern of racketeering activity alleged herein is continuing as of
24 the date of this Complaint and, upon information and belief, will continue into the
25 future unless enjoined by this Court.

26 717. Many of the precise dates of the RICO Diversion Defendants'
27 criminal actions at issue herein were hidden and cannot be alleged without access
28 to their books and records. Indeed, an essential part of the successful operation of

1 the Opioid Diversion Enterprise depended upon the secrecy of the participants in
2 that enterprise.

3 718. Each instance of racketeering activity alleged herein was related, had
4 similar purposes, involved the same or similar participants and methods of
5 commission, and had similar results affecting similar victims, Plaintiffs'
6 Community and the County. Defendants calculated and intentionally crafted the
7 diversion scheme to increase and maintain profits from unlawful sales of opioids,
8 without regard to the effect such behavior would have on this jurisdiction, its
9 citizens or the County. The Defendants were aware that the County and the
10 citizens of this jurisdiction rely on the Defendants to maintain a closed system of
11 manufacturing and distribution to protect against the non-medical diversion and
12 use of their dangerously addictive opioid drugs.

13 719. By intentionally refusing to report and halt suspicious orders of their
14 prescription opioids, Defendants engaged in a fraudulent scheme and unlawful
15 course of conduct constituting a pattern of racketeering activity.

16 720. The RICO Diversion Defendants' predicate acts and pattern of
17 racketeering activity were a substantial and foreseeable cause of the County's
18 injury and the relationship between the RICO Diversion Defendants' conduct and
19 the County's injury are logical and not speculative. It was foreseeable to the
20 RICO Diversion Defendants that when they refused to identify, report and halt
21 suspicious orders as required by the CSA and Code of Federal Regulations, it
22 would allow the wide-spread diversion of prescriptions opioids into the illicit
23 market and create an opioid-addiction epidemic that logically, substantially, and
24 foreseeably harmed the County.

25 721. The RICO Diversion Defendants' predicate acts and pattern of
26 racketeering activity were a substantial and foreseeable cause of the County's
27 injury and the relationship between the RICO Diversion Defendants' conduct and
28 the County's injury is logical and not speculative. It was foreseeable to the RICO

1 Diversion Defendants that when they fraudulently marketed highly-addictive and
2 dangerous drugs, that were approved for very limited and specific uses by the
3 FDA, as non-addictive and safe for off-label uses such as moderate pain, non-
4 cancer pain, and long-term chronic pain, that the RICO Diversion Defendants
5 would create an opioid-addiction epidemic that logically, substantially and
6 foreseeably harmed the County.

7 722. The last racketeering incident occurred within five years of the
8 commission of a prior incident of racketeering.

9 **2. The RICO Diversion Defendants Engaged in Mail and
10 Wire Fraud.**

11 723. The RICO Diversion Defendants carried out, or attempted to carry
12 out, a scheme to defraud federal and state regulators, and the American public by
13 knowingly conducting or participating in the conduct of the Opioid Diversion
14 Enterprise through a pattern of racketeering activity within the meaning of 18
15 U.S.C. § 1961(1) that employed the use of mail and wire facilities, in violation of
16 18 U.S.C. § 1341 (mail fraud) and § 1343 (wire fraud).

17 724. The RICO Diversion Defendants committed, conspired to commit,
18 and/or aided and abetted in the commission of at least two predicate acts of
19 racketeering activity (*i.e.* violations of 18 U.S.C. §§ 1341 and 1343) within the
20 past ten years. The multiple acts of racketeering activity that the RICO Diversion
21 Defendants committed, or aided and abetted in the commission of, were related to
22 each other, posed a threat of continued racketeering activity, and therefore
23 constitute a “pattern of racketeering activity.” The racketeering activity was made
24 possible by the RICO Diversion Defendants’ regular use of the facilities, services,
25 distribution channels, and employees of the Opioid Diversion Enterprise. The
26 RICO Diversion Defendants participated in the scheme to defraud by using mail,
27 telephone and the Internet to transmit mailings and wires in interstate or foreign
28 commerce.

1 725. The RICO Diversion Defendants used, directed the use of, and/or
2 caused to be used, thousands of interstate mail and wire communications in
3 service of their scheme through virtually uniform misrepresentations,
4 concealments and material omissions regarding their compliance with their
5 mandatory reporting requirements and the actions necessary to carry out their
6 unlawful goal of selling prescription opioids without reporting suspicious orders
7 or the diversion of opioids into the illicit market.

8 726. In devising and executing the illegal scheme, the RICO Diversion
9 Defendants devised and knowingly carried out a material scheme and/or artifice to
10 defraud by means of materially false or fraudulent pretenses, representations,
11 promises, or omissions of material facts. For the purpose of executing the illegal
12 scheme, the RICO Diversion Defendants committed these racketeering acts,
13 which number in the thousands, intentionally and knowingly with the specific
14 intent to advance the illegal scheme.

15 727. The RICO Diversion Defendants' predicate acts of racketeering (18
16 U.S.C. § 1961(1)) include, but are not limited to:

17 a. Mail Fraud: The RICO Defendants violated 18 U.S.C. § 1341 by
18 sending or receiving, or by causing to be sent and/or received, materials
19 via U.S. mail or commercial interstate carriers for the purpose of
20 executing the unlawful scheme to design, manufacture, market, and sell
21 the prescription opioids by means of false pretenses, misrepresentations,
22 promises, and omissions.

23 b. Wire Fraud: The RICO Defendants violated 18 U.S.C. § 1343 by
24 transmitting and/or receiving, or by causing to be transmitted and/or
25 received, materials by wire for the purpose of executing the unlawful
26 scheme to design, manufacture, market, and sell the prescription opioids
27 by means of false pretenses, misrepresentations, promises, and
28 omissions.

1 728. The RICO Diversion Defendants' use of the mail and wires includes,
2 but is not limited to, the transmission, delivery, or shipment of the following by
3 the Manufacturers, Distributors, or third parties that were foreseeably caused to be
4 sent as a result of the RICO Diversion Defendants' illegal scheme, including but
5 not limited to:

- 6 a. The prescription opioids themselves;
- 7 b. Documents and communications that supported and/or facilitated the
8 Defendants' request for higher aggregate production quotas, individual
9 production quotas, and procurement quotas;
- 10 c. Documents and communications that facilitated the manufacture,
11 purchase and sale of prescription opioids;
- 12 d. Defendants' DEA registrations;
- 13 e. Documents and communications that supported and/or facilitated
14 Defendants' DEA registrations;
- 15 f. Defendants' records and reports that were required to be submitted to the
16 DEA pursuant to 21 U.S.C. § 827;
- 17 g. Documents and communications related to the Defendants' mandatory
18 DEA reports pursuant to 21 U.S.C. § 823 and 21 C.F.R. § 1301.74;
- 19 h. Documents intended to facilitate the manufacture and distribution of
20 Defendants' prescription opioids, including bills of lading, invoices,
21 shipping records, reports and correspondence;
- 22 i. Documents for processing and receiving payment for prescription
23 opioids;
- 24 j. Payments from the Distributors to the Manufacturers;
- 25 k. Rebates and chargebacks from the Manufacturers to the Distributors;
- 26 l. Payments to Defendants' lobbyists through the PCF;
- 27 m. Payments to Defendants' trade organizations, like the HDA, for
28 memberships and/or sponsorships;

1 n. Deposits of proceeds from Defendants' manufacture and distribution of
 2 prescription opioids; and
 3 o. Other documents and things, including electronic communications.

4 729. On information and belief, the RICO Diversion Defendants (and/or
 5 their agents), for the purpose of executing the illegal scheme, sent and/or received
 6 (or caused to be sent and/or received) by mail or by private or interstate carrier,
 7 shipments of prescription opioids and related documents by mail or by private
 8 carrier affecting interstate commerce, including the following:

Defendant Group Name	Company Names	Drugs		
		Drug Name	Chemical Name	CSA Schedule
Purdue	(1) Purdue Pharma, LP, (2) Purdue Pharma, Inc., (3) The Purdue Frederick Company	OxyContin	Oxycodone hydrochloride extended release	Schedule II
		MS Contin	Morphine sulfate extended release	Schedule II
		Dilaudid	Hydromorphone hydrochloride	Schedule II
		Dilaudid-HP	Hydromorphone hydrochloride	Schedule II
		Butrans	Buprenorphine	Schedule II
		Hysinga ER	Hydrocodone bitrate	Schedule II
		Targiniq ER	Oxycodone hydrochloride	Schedule II
Cephalon	(1) Cephalon, Inc., (2) Teva Pharmaceutical Industries, Ltd., (3) Teva Pharmaceuticals USA, Inc.	Actiq	Fentanyl citrate	Schedule II
		Fentora	Fentanyl citrate	Schedule II
		Generic oxycontin	Oxycodone hydrochloride	Schedule II
Endo	(1) Endo Health Solutions, Inc., (2) Endo Pharmaceuticals Inc., (3) Qualitest Pharmaceuticals, Inc. (wholly-owned subsidiary of Endo)	Opana ER	Oxymorphone hydrochloride extended release	Schedule II
		Opana	Oxymorphone hydrochloride	Schedule II
		Percodan	Oxymorphone hydrochloride and aspirin	Schedule II
		Percocet	Oxymorphone hydrochloride and acetaminophen	Schedule II
		Generic oxycodone		Schedule II
		Generic oxymorphone		Schedule II

Defendant Group Name	Company Names	Drugs		
		Drug Name	Chemical Name	CSA Schedule
		Generic hydromorphone		Schedule II
Mallinckrodt	(1) Mallinckrodt PLC, (2) Mallinckrodt LLC (wholly-owned subsidiary of Mallinckrodt PLC)	Exalgo	Hydromorphone hydrochloride	Schedule II
		Roxicodone	Oxycodone hydrochloride	Schedule II
Allergan	(1) Allergan Plc, (2) Actavis LLC, (3) Actavis Pharma, Inc., (4) Actavis Plc, (5) Actavis, Inc., (6) Watson Pharmaceuticals, Inc., (7) Watson Pharma, Inc.	Kadian	Morphine Sulfate	Schedule II
		Norco (Generic of Kadian)	Hydrocodone and acetaminophen	Schedule II
		Generic Duragesic	Fentanyl	Schedule II
		Generic Opana	Oxymorphone hydrochloride	Schedule II

730. Each of the RICO Diversion Defendants identified manufactured, shipped, paid for and received payment for the drugs identified above, throughout the United States.

731. The RICO Diversion Defendants also used the internet and other electronic facilities to carry out their scheme and conceal the ongoing fraudulent activities. Specifically, the RICO Diversion Defendants made misrepresentations about their compliance with Federal and State laws requiring them to identify, investigate and report suspicious orders of prescription opioids and/or diversion of the same into the illicit market.

732. At the same time, the RICO Diversion Defendants misrepresented the superior safety features of their order monitoring programs, ability to detect suspicious orders, commitment to preventing diversion of prescription opioids, and their compliance with all state and federal regulations regarding the identification and reporting of suspicious orders of prescription opioids.

733. Upon information and belief, the RICO Diversion Defendants utilized the internet and other electronic resources to exchange communications,

1 to exchange information regarding prescription opioid sales, and to transmit
2 payments and rebates/chargebacks.

3 734. The RICO Diversion Defendants also communicated by U.S. Mail,
4 by interstate facsimile, and by interstate electronic mail with each other and with
5 various other affiliates, regional offices, regulators, distributors, and other third-
6 party entities in furtherance of the scheme.

7 735. The mail and wire transmissions described herein were made in
8 furtherance of Defendants' scheme and common course of conduct to deceive
9 regulators, the public and The County that Defendants were complying with their
10 state and federal obligations to identify and report suspicious orders of
11 prescription opioids all while Defendants were knowingly allowing millions of
12 doses of prescription opioids to divert into the illicit drug market. The RICO
13 Diversion Defendants' scheme and common course of conduct was to increase or
14 maintain high production quotas for their prescription opioids from which they
15 could profit.

16 736. Many of the precise dates of the fraudulent uses of the U.S. mail and
17 interstate wire facilities have been deliberately hidden by Defendants and cannot
18 be alleged without access to Defendants' books and records. However, Plaintiffs
19 have described the types of, and in some instances, occasions on which the
20 predicate acts of mail and/or wire fraud occurred. They include thousands of
21 communications to perpetuate and maintain the scheme, including the things and
22 documents described in the preceding paragraphs.

23 737. The RICO Diversion Defendants did not undertake the practices
24 described herein in isolation, but as part of a common scheme. Various other
25 persons, firms, and corporations, including third-party entities and individuals not
26 named as defendants in this Complaint, may have contributed to and/or
27 participated in the scheme with the RICO Diversion Defendants in these offenses
28 and have performed acts in furtherance of the scheme to increase revenues,

1 increase market share, and /or minimize the losses for the RICO Diversion
2 Defendants.

3 738. The RICO Diversion Defendants aided and abetted others in the
4 violations of the above laws, thereby rendering them indictable as principals in the
5 18 U.S.C. §§ 1341 and 1343 offenses.

6 739. The RICO Diversion Defendants hid from the general public and
7 suppressed and/or ignored warnings from third parties, whistleblowers and
8 governmental entities about the reality of the suspicious orders that the RICO
9 Diversion Defendants were filling on a daily basis – leading to the diversion of
10 hundreds of millions of doses of prescriptions opioids into the illicit market.

11 740. The RICO Diversion Defendants, with knowledge and intent, agreed
12 to the overall objective of their fraudulent scheme and participated in the common
13 course of conduct to commit acts of fraud and indecency in manufacturing and
14 distributing prescription opioids.

15 741. Indeed, for the Defendants' fraudulent scheme to work, each of the
16 Defendants had to agree to implement similar tactics regarding manufacturing
17 prescription opioids and refusing to report suspicious orders.

18 742. As described herein, the RICO Diversion Defendants engaged in a
19 pattern of related and continuous predicate acts for years. The predicate acts
20 constituted a variety of unlawful activities, each conducted with the common
21 purpose of obtaining significant monies and revenues from the sale of their highly
22 addictive and dangerous drugs. The predicate acts also had the same or similar
23 results, participants, victims, and methods of commission. The predicate acts were
24 related and not isolated events.

25 743. The predicate acts all had the purpose of creating the opioid epidemic
26 that substantially injured the County's business and property, while
27 simultaneously generating billion-dollar revenue and profits for the RICO
28 Diversion Defendants. The predicate acts were committed or caused to be

1 committed by the RICO Diversion Defendants through their participation in the
2 Opioid Diversion Enterprise and in furtherance of its fraudulent scheme.

3 744. The pattern of racketeering activity alleged herein and the Opioid
4 Diversion Enterprise are separate and distinct from each other. Likewise,
5 Defendants are distinct from the enterprise.

6 745. The pattern of racketeering activity alleged herein is continuing as of
7 the date of this Complaint and, upon information and belief, will continue into the
8 future unless enjoined by this Court.

9 746. Many of the precise dates of the RICO Diversion Defendants'
10 criminal actions at issue here have been hidden by Defendants and cannot be
11 alleged without access to Defendants' books and records. Indeed, an essential part
12 of the successful operation of the Opioid Diversion Enterprise alleged herein
13 depended upon secrecy.

14 747. Each instance of racketeering activity alleged herein was related, had
15 similar purposes, involved the same or similar participants and methods of
16 commission, and had similar results affecting similar victims, including Plaintiffs'
17 Community and the County. Defendants calculated and intentionally crafted the
18 Opioid Diversion Enterprise and their scheme to increase and maintain their
19 increased profits, without regard to the effect such behavior would have on
20 Plaintiffs' Community, its citizens or the County. In designing and implementing
21 the scheme, at all times Defendants were cognizant of the fact that those in the
22 manufacturing and distribution chain rely on the integrity of the pharmaceutical
23 companies and ostensibly neutral third parties to provide objective and reliable
24 information regarding Defendants' products and their manufacture and
25 distribution of those products. The Defendants were also aware that The County
26 and the citizens of this jurisdiction rely on the Defendants to maintain a closed
27 system and to protect against the non-medical diversion and use of their
28 dangerously addictive opioid drugs.

1 748. By intentionally refusing to report and halt suspicious orders of their
2 prescription opioids, Defendants engaged in a fraudulent scheme and unlawful
3 course of conduct constituting a pattern of racketeering activity.

4 749. It was foreseeable to Defendants that The County would be harmed
5 when they refused to report and halt suspicious orders, because their violation of
6 the duties imposed by the CSA and Code of Federal Regulations allowed the
7 widespread diversion of prescription opioids out of appropriate medical channels
8 and into the illicit drug market – causing the opioid epidemic that the CSA
9 intended to prevent.

10 750. The last racketeering incident occurred within five years of the
11 commission of a prior incident of racketeering.

12 **D. DAMAGES.**

13 **1. Impact of the Opioid Diversion Enterprise.**

14 751. California has been especially ravaged by the national opioid crisis.

15 752. More people die each year from drug overdoses in California than in
16 any other state.⁴⁹⁸ The State's death rate has continued to climb, increasing by 30
17 percent from 1999 to 2015, according to the Center for Disease Control (CDC).⁴⁹⁹

18 753. In 2016, 1,925 Californians died due to prescription opioids.⁵⁰⁰ This
19 number is on par with other recent years: in 2015, 1,966 deaths in California were
20 due just to prescription opioids (not including heroin); in 2014 that number was
21 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians
22 died from a prescription opioid overdose.⁵⁰¹

23
24
25

⁴⁹⁸ Davis, *supra*.

26 ⁴⁹⁹ Karlamangla, *supra*.

27 ⁵⁰⁰ Davis, *supra*.

28 ⁵⁰¹California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last visited March 2, 2018).

1 754. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was
 2 a factor in at least 234 of them.⁵⁰² This is an increase of 47 percent for 2016.⁵⁰³
 3 Heroin-related deaths have risen by 67 percent in California since 2006.⁵⁰⁴

4 755. The high number of deaths are due in part to the extraordinary
 5 number of opioids prescribed in the State. Over 23.6 million prescriptions for
 6 opioids were written in California in just 2016.⁵⁰⁵

7 756. The California Department of Public Health tracks the number of
 8 reported hospitalizations and emergency department visits due to prescription
 9 opioids.⁵⁰⁶ In 2015, the last year for which information is currently available,
 10 California had 3,935 emergency department visits and 4,095 hospitalizations
 11 related to prescription opioid overdoses (excluding heroin).⁵⁰⁷ The numbers were
 12 even higher in 2014, when 4,106 people visited the emergency department and
 13 4,482 people were hospitalized due to prescription opioid abuse.⁵⁰⁸ In 2013, there
 14 were 3,964 emergency department visits and 4,344 hospitalizations for
 15 prescription opioid overdoses.⁵⁰⁹ When emergency visits and hospitalizations
 16 include heroin, the numbers are even higher.⁵¹⁰

17
 18
 19

 20 ⁵⁰² Davis, *supra*.

21 ⁵⁰³ Karlamangla, *supra*.

22 ⁵⁰⁴ California Department of Public Health, *State of California Strategies to*
 23 *Address Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in*
 24 *California* at 3 (June 2016), available at
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

25 ⁵⁰⁵ California Department of Public Health, *California Opioid Overdose*
Surveillance Dashboard, *supra*.

26 ⁵⁰⁶ *Id.*

27 ⁵⁰⁷ *Id.*

28 ⁵⁰⁸ *Id.*

29 ⁵⁰⁹ *Id.*

30 ⁵¹⁰ *Id.*

1 757. NAS has increased dramatically in California, with the rate of infants
 2 born with NAS more than tripling from 2008 to 2013.⁵¹¹ While the number of
 3 affected newborns rose from 1,862 in 2008 to 3,007 in 2014, that number jumped
 4 by another 21 percent in 2015.⁵¹² This is despite a steady decline in the overall
 5 number of birth in California during that same time.⁵¹³

6 758. Reports from California's Office of Statewide Health Planning,
 7 which collects data from licensed health care facilities, have shown a 95 percent
 8 increase between 2008 and 2015 of newborns affected by drugs transmitted via
 9 placenta or breast milk.⁵¹⁴

10 759. The opioid epidemic has also had an impact on crime in California.
 11 Pharmacy robberies have gone up by 163 percent in California over the last two
 12 years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in
 13 2016 and, through mid-November of 2017, that number had climbed to 237.⁵¹⁵
 14 Most perpetrators were after prescription opioids.⁵¹⁶ In addition, fentanyl seizures
 15 at California ports increased 266 percent in fiscal year 2017.⁵¹⁷

16 760. The opioid epidemic is particularly devastating in Plaintiffs'
 17 Community.

18

19

20

21 ⁵¹¹ California Child Welfare Co-Investment Partnership, *supra* at 5.

22 ⁵¹² Clark, *supra*.

23 ⁵¹³ *Id.*

24 ⁵¹⁴ California Child Welfare Co-Investment Partnership, *supra*.

25 ⁵¹⁵ Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited March 2, 2018)).

26 ⁵¹⁶ *Id.*

27 ⁵¹⁷ United State Department of Justice, The United States Attorney's Office,
 28 Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb. 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

1 761. In 2016, the County had an opioid overdose death rate of 13.4, the
 2 eighth highest in the State.⁵¹⁸ In 2015, the County's opioid overdose death rate
 3 was in the highest quartile in the State.⁵¹⁹

4 762. Prescription opioids have also been responsible for a high rate of
 5 emergency department visits in the County. In 2016, Trinity County had a rate of
 6 40.8 emergency department visits due to opioid overdoses (excluding heroin) per
 7 100,000 people, the fourth highest rate in the State that year.⁵²⁰

8 763. In 2016, an estimated seven percent of the population aged 12 and up
 9 in Trinity County misused opioids and about 1.3 percent had an opioid use
 10 disorder.⁵²¹

11 764. The CDC has tracked prescription rates per county in the United
 12 States, identifying the geographic "hotspots" for rates of opioid prescriptions.⁵²²
 13 The CDC has calculated the geographic distribution at county levels of opioid
 14 prescriptions dispensed per 100 persons,⁵²³ revealing that Trinity County has been
 15 a consistent hotspot over at least the past decade.

16
 17
 18 ⁵¹⁸ California Department of Public Health, *California Opioid Overdose*
 19 *Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last
 20 visited April 23, 2018) (Trinity County specific page).

21 ⁵¹⁹ Public Health Institute, Tackling An Epidemic: An Assessment of the California
 22 Opioid Safety Coalitions Network, at p. 11, available at
<https://www.phi.org/uploads/application/files/bt93oju0nrnbsmjhpdw692ljgu0d27ttdpzxmbclj7cxq99alz.pdf> (last visited April 20, 2018).

23 ⁵²⁰ California Department of Public Health, *California Opioid Overdose*
 24 *Surveillance Dashboard*, available at https://pdop.shinyapps.io/ODdash_v1/ (last
 25 visited April 20, 2018) (Trinity County specific page).

26 ⁵²¹ Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, "County-Level
 27 Estimates of Opioid Use Disorder and Treatment Needs in California," *The Urban*
 28 *Institute*, March 19, 2018, available at
<https://www.urban.org/sites/default/files/trinity.pdf> (last visited April 23, 2018).

27 ⁵²² U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 28 2017).

⁵²³ *Id.*

1 765. The CDC's statistics prove that the opioid prescription rates in
 2 Trinity County have exceeded any legitimate medical, scientific, or industrial
 3 purpose. The overall opioid prescribing rate in 2016 was 66.5 prescriptions per
 4 100 people and 44.8 in California.⁵²⁴ However, in Trinity County, California, the
 5 2016 prescription rate was 98.5 per 100 people.⁵²⁵ This is down from the 2015
 6 prescribing rate for Trinity County which was 110.2 per 100 people – more than
 7 one prescription for every man, woman and child in Trinity County.⁵²⁶

8 766. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions
 9 were not an aberration for Trinity County. Consistently, the opioid prescribing
 10 rates in Trinity County have been significantly greater than the national and state
 11 averages, and well more than one prescription per person living in the County.
 12 Compared to a national average of 75.6 opioid prescriptions per 100 people in
 13 2014⁵²⁷ and 52.7 in California,⁵²⁸ the Trinity County opioid prescription rate was
 14 119.6 per 100 people, more than double the State prescribing rate.⁵²⁹ In 2013, the
 15
 16
 17

18 ⁵²⁴ *Id.* See also U.S. State Prescribing Rates, 2016, available at
 19 <https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,
 2018).

20 ⁵²⁵ U.S. County Prescribing Rates, 2016, (reporting for “Trinity, CA” here and
 21 below) CDC available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,
 2018).

22 ⁵²⁶ U.S. County Prescribing Rates, 2015, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,
 2018).

23 ⁵²⁷ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

24 ⁵²⁸ U.S. State Prescribing Rates, 2014, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,
 2017).

25 ⁵²⁹ U.S. County Prescribing Rates, 2014, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,
 2018).

1 national average was 78.1 opioid prescriptions per 100 people,⁵³⁰ but the opioid
2 prescription rate in Trinity County was 117 per 100 people.⁵³¹ Compared to a
3 national average of 81.3 opioid prescriptions per 100 people in 2012,⁵³² the opioid
4 prescription rate in Trinity County was 126.7 per 100 people that year.⁵³³ In 2011,
5 the national average was 80.9 opioid prescriptions per 100 people,⁵³⁴ but the
6 opioid prescription rate in Trinity County was 135.6 per 100 people.⁵³⁵ Compared
7 to a national average of 81.2 opioid prescriptions per 100 people in 2010,⁵³⁶ the
8 Trinity County opioid prescription rate was 144.9 per 100 people.⁵³⁷ In 2009, the
9 national average was 79.5 opioid prescriptions per 100 people,⁵³⁸ but the rate in
10 Trinity County was 121.4 per 100.⁵³⁹ Compared to a national average of 78.2

11

12 ⁵³⁰ U.S. Prescribing Rate Maps, CDC, available at
13 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
14 2017).

15 ⁵³¹ U.S. County Prescribing Rates, 2013, CDC, available at
16 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,
17 2018).

18 ⁵³² U.S. Prescribing Rate Maps, CDC, available at
19 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
20 2017).

21 ⁵³³ U.S. County Prescribing Rates, 2012, CDC, available at
22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,
23 2018).

24 ⁵³⁴ U.S. Prescribing Rate Maps, CDC, available at
25 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
26 2017).

27 ⁵³⁵ U.S. County Prescribing Rates, 2011, CDC, available at
28 <https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,
29 2018).

⁵³⁶ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
2017).

⁵³⁷ U.S. County Prescribing Rates, 2010, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18,
2018).

⁵³⁸ U.S. Prescribing Rate Maps, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
2017).

⁵³⁹ U.S. County Prescribing Rates, 2009, CDC, available at
<https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18,
2018).

1 opioid prescriptions per 100 people in 2008⁵⁴⁰ and 55.1 in California,⁵⁴¹ the
 2 Trinity County rate was 116.8 per 100 people.⁵⁴² In 2007, the national average
 3 was 75.9 opioid prescriptions per 100 people,⁵⁴³ but the Trinity County rate was
 4 117.9 per 100 people.⁵⁴⁴ Compared to a national average of 72.4 opioid
 5 prescriptions per 100 people prescribed opioids in 2006,⁵⁴⁵ the Trinity County rate
 6 was 120.5 per 100 people.⁵⁴⁶

7 **2. The Relief Sought.**

8 767. The RICO Diversion Defendants' violations of law and their pattern
 9 of racketeering activity directly and proximately caused the County injury in its
 10 business and property. The RICO Diversion Defendants' pattern of racketeering
 11 activity, including their refusal to identify, report and halt suspicious orders of
 12 controlled substances, logically, substantially and foreseeably cause an opioid
 13 epidemic. The County was injured by the RICO Diversion Defendants' pattern of
 14 racketeering activity and the opioid epidemic that they created.

15

16

17 ⁵⁴⁰ U.S. Prescribing Rate Maps, CDC, available at
 18 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

19 ⁵⁴¹ U.S. State Prescribing Rates, 2018, CDC, available at
 20 <https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11,
 2017).

21 ⁵⁴² U.S. County Prescribing Rates, 2008, CDC, available at
 22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18,
 2018).

23 ⁵⁴³ U.S. Prescribing Rate Maps, CDC, available at
 24 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,,
 2017).

25 ⁵⁴⁴ U.S. County Prescribing Rates, 2007, CDC, available at
 26 <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18,
 2018).

27 ⁵⁴⁵ U.S. Prescribing Rate Maps, CDC, available at
 28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,
 2017).

29 ⁵⁴⁶ U.S. County Prescribing Rates, 2006, CDC, available at
 30 <https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18,
 2018).

1 768. As the County alleges, the RICO Diversion Defendants knew that the
 2 opioids they manufactured and supplied were unsuited to treatment of long-term,
 3 chronic, non-acute, and non-cancer pain, or for any other use not approved by the
 4 FDA, and knew that opioids were highly addictive and subject to abuse.⁵⁴⁷
 5 Nevertheless, the RICO Diversion Defendants engaged in a scheme of deception,
 6 that utilized the mail and wires as part of their fraud, in order to increase sales of
 7 their opioid products by refusing to identify, report suspicious orders of
 8 prescription opioids that they knew were highly addictive, subject to abuse, and
 9 were actually being diverted into the illegal market.⁵⁴⁸

10 769. Here, as the County alleges, the link of causation generally breaks
 11 down into three very short steps: (1) the RICO Diversion Defendants' affirmative
 12 action to continue supplying prescription opioids through legal channels with
 13 knowledge that they were being diverted into the illicit market; (2) an opioid
 14 epidemic in the form of criminal drug trafficking, misuse and abuse; and (3)
 15 injuries to the County.⁵⁴⁹ Although not as direct as a car accident or a slip-and-fall
 16 case, this causal chain is still a "direct sequence" and a logical, substantial and
 17 foreseeable cause of the County's injury.⁵⁵⁰

18 770. Specifically, the RICO Diversion Defendants' predicate acts and
 19 pattern of racketeering activity caused the opioid epidemic which has injured the
 20 County in the form of substantial losses of money and property that logically,
 21 directly and foreseeably arise from the opioid-addiction epidemic. The County's
 22 injuries, as alleged throughout this complaint, and expressly incorporated herein
 23 by reference, include:

24
 25 ⁵⁴⁷ *Traveler's Property Casualty Company of America v. Actavis, Inc.*, 22 Cal.
 26 Rptr. 3d 5, 19 (Cal. Ct. App. 2017).

27 ⁵⁴⁸ *City of Everett v. Purdue Pharma L.P.*, 2017 WL 4236062, *6 (W.D. Wash.
 28 Sept. 25, 2017).

⁵⁴⁹ *Id.*

⁵⁵⁰ *Id.*

- 1 a. Losses caused by purchasing and/or paying reimbursements for the
2 RICO Defendants' prescription opioids, that The County would not have
3 paid for or purchased but for the RICO Diversion Defendants' conduct;
- 4 b. Losses caused by the decrease in funding available for The County's
5 public services for which funding was lost because it was diverted to
6 other public services designed to address the opioid epidemic;
- 7 c. Costs for providing healthcare and medical care, additional therapeutic,
8 and prescription drug purchases, and other treatments for patients
9 suffering from opioid-related addiction or disease, including overdoses
10 and deaths;
- 11 d. Costs of training emergency and/or first responders in the proper
12 treatment of drug overdoses;
- 13 e. Costs associated with providing police officers, firefighters, and
14 emergency and/or first responders with Naloxone – an opioid antagonist
15 used to block the deadly effects of opioids in the context of overdose;
- 16 f. Costs associated with emergency responses by police officers,
17 firefighters, and emergency and/or first responders to opioid overdoses;
- 18 g. Costs for providing mental-health services, treatment, counseling,
19 rehabilitation services, and social services to victims of the opioid
20 epidemic and their families;
- 21 h. Costs for providing treatment of infants born with opioid-related medical
22 conditions, or born addicted to opioids due to drug use by mother during
23 pregnancy;
- 24 i. Costs associated with law enforcement and public safety relating to the
25 opioid epidemic, including but not limited to attempts to stop the flow of
26 opioids into local communities, to arrest and prosecute street-level
27 dealers, to prevent the current opioid epidemic from spreading and
28 worsening, and to deal with the increased levels of crimes that have

1 directly resulted from the increased homeless and drug-addicted
2 population;

3 j. Costs associated with increased burden on the County's judicial system,
4 including increased security, increased staff, and the increased cost of
5 adjudicating criminal matters due to the increase in crime directly
6 resulting from opioid addiction;

7 k. Costs associated with providing care for children whose parents suffer
8 from opioid-related disability or incapacitation;

9 l. Loss of tax revenue due to the decreased efficiency and size of the
10 working population in Plaintiffs' Community;

11 m. Losses caused by diminished property values in neighborhoods where
12 the opioid epidemic has taken root; and

13 n. Losses caused by diminished property values in the form of decreased
14 business investment and tax revenue.

15 771. The County's injuries were proximately caused by Defendants'
16 racketeering activities because they were the logical, substantial and foreseeable
17 cause of The County's injuries. But for the opioid-addiction epidemic created by
18 Defendants' conduct, The County would not have lost money or property.

19 772. The County's injuries were directly caused by the RICO Diversion
20 Defendants' pattern of racketeering activities.

21 773. The County is most directly harmed and there is no other Plaintiff
22 better suited to seek a remedy for the economic harms at issue here.

23 774. Plaintiff seeks all legal and equitable relief as allowed by law,
24 including *inter alia* actual damages, treble damages, equitable relief, forfeiture as
25 deemed proper by the Court, attorney's fees and all costs and expenses of suit and
26 pre- and post-judgment interest

27
28

**COUNT V
FALSE ADVERTISING
Business and Professions C**

Violations of California Business and Professions Code section 17500, et seq.
(Against All Defendants)

775. Plaintiff, The People, incorporate by reference all other paragraphs of this Complaint as if fully set forth here, and further alleges as follows.

776. This Count is brought by the People of the State. This Count is brought pursuant to Sections 17535 and 17536 of the California Business and Professions Code for injunctive relief, restitution and civil penalties.

777. Section 17500 of the California Business and Professions Code makes it “unlawful for any person, . . . corporation . . . with intent directly or indirectly to dispose of real or personal property . . . or to induce the public to enter into any obligation relating thereto, to make or disseminate or cause to be made or disseminated before the public in this state, . . . in any . . . manner or means whatever . . . any statement, concerning that real or personal property . . . which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading.” Cal. Bus. & Prof. Code § 17500.

778. As described above in allegations expressly incorporated herein, at all times relevant to this Complaint, Defendants directly and indirectly violated Section 17500 by making and disseminating untrue, false and misleading statements about, *inter alia*, the use of opioids for chronic pain, about the risks of addiction related to opioids, about the signs of addiction and how to reliably identify and safely prescribe opioids to patients predisposed to addiction, and about their so-called abuse-deterrent opioid formulations. Defendants also repeatedly failed to disclose material facts about the risks of opioids.

779. The Manufacturer Defendants also made untrue, false, and misleading statements that included, but were not limited to:

1 780. Claiming or implying that opioids would improve patients' function
2 and quality of life;

3 781. Claiming that opioids should be used to treat chronic pain and that
4 there was a significant upside to long-term opioid use;

5 782. Mischaracterizing the risk of opioid addiction and abuse, including
6 by stating or implying the opioids were rarely addictive, that "steady state" and
7 abuse-resistant properties meant the drugs were less likely to be addictive or
8 abused, and that specific opioid drugs were less addictive or less likely to be
9 abused than other opioids;

10 783. Claiming or implying that addiction can be avoided or successfully
11 managed through the use of screening and other tools and exaggerating the
12 effectiveness of screening tools to prevent addiction;

13 784. Promoting the misleading concept of pseudoaddiction, thus
14 concealing the true risk of addiction, and advocating that the signs of addiction
15 should be treated with more opioids;

16 785. Mischaracterizing the difficulty of discontinuing opioid therapy,
17 including by mischaracterizing the prevalence and severity of withdrawal
18 symptoms, and claiming that opioid dependence and withdrawal are easily
19 managed;

20 786. Claiming of implying that increased doses of opioids pose no
21 significant additional risk;

22 787. Misleadingly depicting the safety profile of opioids prescribed by
23 minimizing their risks and adverse effects while emphasizing or exaggerating the
24 risks of competing products, including NSAIDs; and

25 788. In the case of Purdue, mischaracterizing OxyContin's onset of action
26 and duration of efficacy to imply that the drug provided a full 12 hours of pain
27 relief.

1 789. The Manufacturer Defendants made deceptive representations to the
2 public about the use of opioids to treat chronic non-cancer pain. Each
3 Manufacturer Defendant also omitted or concealed material facts and failed to
4 correct prior misrepresentations and omissions to the public about the risks and
5 benefits of opioids. Each Defendant's omissions rendered even their seemingly
6 truthful statements about opioids deceptive.

7 790. Defendants' conduct was likely to mislead or deceive The People and
8 Plaintiffs' Community, including Californians who purchased or covered or paid
9 for the purchase of opioids for chronic pain.

10 791. Each Manufacturer Defendant has conducted, and has continued to
11 conduct, a widespread marketing scheme designed to promote opioids and
12 persuade doctors and patients that opioids can and should be used for chronic
13 pain, resulting in opioid treatment for a far broader group of patients who are
14 much more likely to become addicted and suffer other adverse effects from the
15 long-term use of opioids. In connection with this scheme, each Manufacturer
16 Defendant spent, and continues to spend, millions of dollars on promotional
17 activities and materials that falsely deny or trivialize the risks of opioids while
18 overstating the benefits of using them for chronic pain. This conduct tends to
19 mislead or deceive, and has misled and deceived, The People and Plaintiffs'
20 Community.

21 792. The Manufacturer Defendants have disseminated these common
22 messages to reverse the popular and medical understanding of opioids and risks of
23 opioid use. They disseminated these messages directly, through their sales
24 representatives, in speaker groups led by physicians the Manufacturer Defendants
25 recruited for their support of their marketing messages, and through unbranded
26 marketing and industry-funded front groups.

27 793. Pursuant to Section 17535 of the California Business and Professions
28 Code, The People request an order from this Court enjoining Defendants from any

1 further violations of the California False Advertising law, California Business and
2 Professions Code §§ 17500 *et seq.*

3 794. Pursuant to Section 17535 of the California Business and Professions
4 Code, the People request restitution of any money acquired by Defendants'
5 violations of the California False Advertising law, California Business and
6 Professions Code §§ 17500 *et seq.*

7 795. Pursuant to Section 17536 of the California Business and Professions
8 Code, The People request an order assessing a civil penalty of two thousand five
9 hundred dollars (\$2,500) against Defendants for each violation of the California
10 False Advertising law, California Business and Professions Code §§ 17500 *et seq.*

11 **COUNT VI**

12 **NEGLIGENT MISREPRESENTATION**

13 **(Against All Defendants)**

14 796. Plaintiff, The County, incorporates by reference all other paragraphs
15 of this Complaint as if fully set forth here, and further alleges as follows.

16 797. The County seeks economic damages which were the foreseeable
17 result of the Defendants' intentional and/or unlawful actions and omissions.

18 798. California classifies negligent misrepresentation as a species of fraud
19 or deceit for which economic losses are recoverable. *Kalitta Air, L.L.C. v. Cent.*
20 *Texas Airborne Sys., Inc.*, 315 F. App'x 603, 607 (9th Cir. 2008) (citing *Bily v.*
21 *Arthur Young & Co.*, 3 Cal. 4th 370, 11 Cal. Rptr. 2d 51, 834 P.2d 745, 768
22 (1992)).

23 799. The elements of negligent misrepresentation in California are that the
24 defendant: (1) made a misrepresentation of a past or existing material fact, (2)
25 without reasonable grounds for believing it to be true, (3) with the intent to induce
26 another's reliance on the misrepresentation, (4) justifiable reliance on the
27 misrepresentation, and (5) resulting damage. *Wells Fargo Bank, N.A. v. FSI, Fin.*
28 *Sols., Inc.*, 196 Cal. App. 4th 1559, 1573, 127 Cal. Rptr. 3d 589, 600 (2011); *Fox*

1 *v. Pollack*, 181 Cal. App. 3d 954, 962, 226 Cal. Rptr. 532, 536–37 (Ct. App.
 2 1986). Negligent misrepresentation “encompasses ‘[t]he assertion, as a fact, of
 3 that which is not true, by one who has no reasonable ground for believing it to be
 4 true.’” *Small v. Fritz Companies, Inc.*, 30 Cal. 4th 167, 173–74, 65 P.3d 1255,
 5 1258 (2003) (citing Cal. Civ. Code § 1710(2)).

6 800. As described elsewhere in this Complaint in allegations expressly
 7 incorporated herein, Distributor Defendants misrepresented their compliance with
 8 their duties under the law and concealed their noncompliance and shipments of
 9 suspicious orders of opioids to Plaintiffs’ Community and destinations from
 10 which they knew opioids were likely to be diverted into Plaintiffs’ Community, in
 11 addition to other misrepresentations alleged and incorporated herein.

12 801. As described elsewhere in the Complaint in allegations expressly
 13 incorporated herein, Manufacturer Defendants breached their duties to exercise
 14 due care in the business of pharmaceutical manufacturers of dangerous opioids,
 15 which are Schedule II Controlled Substances, by misrepresenting the nature of the
 16 drugs and aggressively promoting them for chronic pain for which they knew the
 17 drug were not safe or suitable.

18 802. The Manufacturer Defendants misrepresented and concealed the
 19 addictive nature of prescription opioids and their lack of suitability for chronic
 20 pain, in addition to other misrepresentations alleged and incorporated herein.

21 803. All Defendants breached their duties to prevent diversion and report
 22 and halt suspicious orders, and they misrepresented their compliance with their
 23 legal duties. Defendants knew or should have known that the representations they
 24 were making were untrue because they did not have reasonable grounds for
 25 believing their statements to be true.

26 804. Defendants made these false representations and concealed facts with
 27 knowledge of the falsity of their representations, or without reasonable grounds
 28 for believing them to be true, and did so with the intent of inducing reliance by

1 The County, Plaintiffs' Community, the public, and persons on whom The County
2 relied.

3 805. These false representations and concealments were reasonably
4 calculated to deceive The County, Plaintiffs' Community, and the physicians who
5 prescribed opioids for persons in Plaintiffs' Community, were made with the
6 intent of inducing reliance, and did in fact deceive these persons, The County, and
7 Plaintiffs' Community.

8 806. The County, Plaintiffs' Community, and the physicians who
9 prescribed opioids reasonably relied on these false representations and
10 concealments of material fact

11 807. The County justifiably relied on Defendants' representations and/or
12 concealments, both directly and indirectly. This reliance proximately caused The
13 County's injuries.

14 808. The causal connection between the Defendants' breaches of their
15 duties and misrepresentations and the ensuing harm was entirely foreseeable.

16 809. As described above in allegations expressly incorporated herein,
17 Defendants' breaches of duty and misrepresentations caused, bear a causal
18 connection with and/or proximately resulted in the damages sought herein.

19 810. The Defendants' breaches of their duties and misrepresentations were
20 the cause-in-fact of The County's injuries.

21 811. The risk of harm to The County and Plaintiffs' Community and the
22 harm caused should have been reasonably foreseen by Defendants. The
23 Defendants' conduct was substantial factor in causing The County's injuries.

24 812. The Defendants were selling dangerous drugs statutorily categorized
25 as posing a high potential for abuse and severe dependence. The Defendants
26 knowingly traded in drugs that presented a high degree of danger if prescribed
27 incorrectly or diverted to other than medical, scientific, or industrial channels.

1 However, the Defendants misrepresented what their duties were and their
2 compliance with their legal duties.

3 813. The Defendants failed to disclose the material facts that *inter alia*
4 they were not in compliance with laws and regulations requiring that they
5 maintain a system to prevent diversion, protect against addiction and severe harm,
6 and specifically monitor, investigate, report, and refuse suspicious orders. But for
7 these material factual omissions, the Defendants would not have been able to sell
8 opioids.

9 814. As alleged herein, each Manufacturer Defendant wrongfully
10 represented that the opioid prescription medications they manufactured, marketed
11 and sold had characteristics, uses or benefits that they do not have. The
12 Manufacturer Defendants also wrongfully misrepresented that the opioids were
13 safe and effective when the Manufacturer Defendants knew, or should have
14 known, such representations were untrue, false and misleading.

15 815. Because of the dangerously addictive nature of these drugs, which the
16 Manufacturer Defendants concealed and misrepresented, they lacked medical
17 value and in fact caused addiction and overdose deaths.

18 816. The Manufacturer Defendants made deceptive representations about
19 the use of opioids to treat chronic non-cancer pain. Each Manufacturer Defendant
20 also omitted or concealed material facts and failed to correct prior
21 misrepresentations and omissions about the risks and benefits of opioids. Each
22 Defendant's omissions rendered even their seemingly truthful statements about
23 opioids deceptive.

24 817. The Defendants' unlawful and/or intentional actions create a
25 rebuttable presumption of negligent misrepresentation under State law.

26 818. The County seeks economic losses (direct, incidental, or
27 consequential pecuniary losses) resulting from the Defendants' actions and
28 omissions.

1 819. The County seeks all legal and equitable relief as allowed by law,
2 other than such damages disavowed herein, including *inter alia* injunctive relief,
3 restitution, disgorgement of profits, compensatory and punitive damages, and all
4 damages allowed by law to be paid by the Defendants, attorney fees and costs, and
5 pre- and post-judgment interest.

COUNT VII

FRAUD AND FRAUDULENT MISREPRESENTATION

(Against All Defendants)

9 820. Plaintiff, The County, incorporates by reference all other paragraphs
10 of this Complaint as if fully set forth here, and further alleges as follows.

11 821. In California, the tort of fraud or intentional misrepresentation has
12 five elements: ““The elements of fraud, which gives rise to the tort action for
13 deceit, are (a) misrepresentation (false representation, concealment, or
14 nondisclosure); (b) knowledge of falsity (or ‘scienter’); (c) intent to defraud, i.e.,
15 to induce reliance; (d) justifiable reliance; and (e) resulting damage.”” *Small v.*
16 *Fritz Companies, Inc.*, 30 Cal. 4th 167, 173–74, 65 P.3d 1255, 1258 (2003) (citing
17 *Lazar v. Superior Court*, 12 Cal. 4th 631, 638, 49 Cal. Rptr. 2d 377, 909 P.2d 981
18 (1996)).

19 822. Section 1709 of the California Civil Code provides: "Fraudulent
20 deceit. One who willfully deceives another with intent to induce him to alter his
21 position to his injury or risk, is liable for any damage which he thereby suffers."
22 Cal. Civ. Code. § 1709.

23 823. Section 1710 of the California Civil Code provides: "Deceit, what. A
24 deceit, within the meaning of the last section, is either: 1. The suggestion, as a
25 fact, of that which is not true, by one who does not believe it to be true; . . . 3.

26 The suppression of a fact, by one who is bound to disclose it, or who gives
27 information of other facts which are likely to mislead for want of communication
28 of that fact.” Cal. Civ. Code. §§ 1710(1) & (3). “In California, the elements of the

1 misrepresentation torts (which are also denominated forms of “deceit”) are
2 prescribed by statute . . . and our common law tradition.” *Bily v. Arthur Young &*
3 *Co.*, 3 Cal. 4th 370, 414, 834 P.2d 745 (1992) (citing Cal. Civ. Code § 1710).

4 824. Defendants violated their general duty not to actively deceive, have
5 made knowingly false statements and have omitted and/or concealed information
6 which made statements Defendants did make knowingly false. Defendants acted
7 intentionally and/or unlawfully.

8 825. As alleged herein, Defendants made false statements regarding their
9 compliance with state and federal law regarding their duties to prevent diversion,
10 their duties to monitor, report and halt suspicious orders, and/or concealed their
11 noncompliance with these requirements.

12 826. As alleged herein, the Manufacturer Defendants engaged in false
13 representations and concealments of material fact regarding the use of opioids to
14 treat chronic, non-cancer pain.

15 827. As alleged herein, the Defendants knowingly and/or intentionally
16 made representations that were false. Defendants had a duty to disclose material
17 facts and concealed them. These false representations and concealed facts were
18 material to the conduct and actions at issue. Defendants made these false
19 representations and concealed facts with knowledge of the falsity of their
20 representations, and did so with the intent of misleading The County, Plaintiffs’
21 Community, the public, and persons on whom The County relied.

22 828. These false representations and concealments were reasonably
23 calculated to deceive The County, Plaintiffs’ Community, and the physicians who
24 prescribed opioids for persons in Plaintiffs’ Community, were made with the
25 intent to deceive and induce reliance, and did in fact deceive these persons, The
26 County, and Plaintiffs’ Community.

27
28

1 829. The County, Plaintiffs' Community, and the physicians who
2 prescribed opioids reasonably relied on these false representations and
3 concealments of material fact.

4 830. The County justifiably relied on Defendants' representations and/or
5 concealments, both directly and indirectly. The County's injuries were
6 proximately caused by this reliance.

7 831. The injuries alleged by The County herein were sustained as a direct
8 and proximate cause of the Defendants' fraudulent conduct.

9 832. The County seeks economic losses (direct, incidental, or
10 consequential pecuniary losses) resulting from Defendants' fraudulent activity,
11 including fraudulent misrepresentations and fraudulent concealment.

12 833. The County seeks all legal and equitable relief as allowed by law,
13 except as expressly disavowed herein, including *inter alia* injunctive relief,
14 restitution, disgorgement of profits, compensatory damages and punitive damages,
15 and all damages allowed by law to be paid by the Defendants, attorney fees and
16 costs, and pre- and post-judgment interest.

COUNT VIII
UNJUST ENRICHMENT
(Against All Defendants)

20 834. Plaintiff, The County, incorporates by reference all other paragraphs
21 of this Complaint as if fully set forth herein, and further alleges as follows.

22 835. Defendants have unjustly retained a benefit to The County's
23 detriment, and the Defendants' retention of the benefit violates the fundamental
24 principles of justice, equity, and good conscience. *Peterson v. Cellco Partnership*,
25 164 Cal. App. 4th 1583, 1593, 80 Cal. Rptr. 3d 316, 323 (2008); *Lectrodryer v.*
26 *SeoulBank*, 77 Cal. App. 4th 723, 726, 91 Cal. Rptr. 2d 881 (2000).

836. As an expected and intended result of their conscious wrongdoing as
set forth in this Complaint, Defendants have profited and benefited from the

1 increase in the distribution and purchase of opioids within Plaintiffs' Community,
2 including from opioids foreseeably and deliberately diverted within and into
3 Plaintiffs' Community.

4 837. Unjust enrichment arises not only where an expenditure by one party
5 adds to the property of another, but also where the expenditure saves the other
6 from expense or loss.

7 838. The County has expended substantial amounts of money in an effort
8 to remedy or mitigate the societal harms caused by Defendants' conduct.

9 839. These expenditures include the provision of healthcare services and
10 treatment services to people who use opioids.

11 840. These expenditures have helped sustain Defendants' businesses.

12 841. The County has conferred a benefit upon Defendants by paying for
13 Defendants' externalities: the cost of the harms caused by Defendants' improper
14 distribution practices.

15 842. Defendants were aware of these obvious benefits, and their retention
16 of the benefit is unjust.

17 843. The County has paid for the cost of Defendants' externalities and
18 Defendants have benefited from those payments because they allowed them to
19 continue providing customers with a high volume of opioid products. Because of
20 their deceptive marketing of prescription opioids, Manufacturer Defendants
21 obtained enrichment they would not otherwise have obtained. Because of their
22 conscious failure to exercise due diligence in preventing diversion, Defendants
23 obtained enrichment they would not otherwise have obtained. The enrichment
24 was without justification and the County lacks a remedy provided by law.

25 844. Defendants have unjustly retained benefits to the detriment of the
26 County, and Defendants' retention of such benefits violates the fundamental
27 principles of justice, equity, and good conscience.

28

1 845. Defendants' misconduct alleged in this case is ongoing and
2 persistent.

3 846. Defendants' misconduct alleged in this case does not concern a
4 discrete event or discrete emergency of the sort a political subdivision would
5 reasonably expect to occur, and is not part of the normal and expected costs of a
6 local government's existence. The County alleges wrongful acts which are neither
7 discrete nor of the sort a local government can reasonably expect.

8 847. The County has incurred expenditures for special programs over and
9 above its ordinary public services.

10 848. By reason of Defendants' unlawful acts, The County has been
11 damaged and continues to be damaged, in a substantial amount to be determined
12 at trial.

13 849. The County seeks an order compelling Defendants to disgorge all
14 unjust enrichment to the County; and awarding such other, further, and different
15 relief as this Honorable Court may deem just.

PUNITIVE DAMAGES

17 850. Plaintiffs incorporate by reference all other paragraphs of this
18 Complaint as if fully set forth herein, and further alleges as follows.

19 851. By engaging in the above-described intentional and/or unlawful acts
20 or practices, Defendants acted maliciously towards Plaintiffs and with an
21 intentional disregard of the Plaintiffs' rights and the safety of Plaintiffs'
22 Community. Defendants acted oppressively, with conscious disregard for the
23 rights of others and/or in a reckless, wanton, willful or grossly negligent manner.
24 Defendants acted with a prolonged intentional disregard to the adverse
25 consequences of their actions and/or omissions. Defendants acted with a
26 conscious disregard for the rights and safety of others in a manner that had a great
27 probability of causing substantial harm. Defendants acted toward The County with

1 malice and were grossly negligent in failing to perform the duties and obligations
2 imposed upon them under applicable federal and state statutes and common law.

3 852. Defendants also committed fraud by knowingly and intentionally
4 making representations that were false. Defendants had a duty to disclose material
5 facts and concealed them. These false representations and concealed facts were
6 material to the conduct and actions at issue.

7 853. Defendants were selling and/or manufacturing dangerous drugs
8 statutorily categorized as posing a high potential for abuse and severe dependence.
9 Thus, Defendants knowingly traded in drugs that presented a high degree of
10 danger if prescribed incorrectly or diverted to other than legitimate medical,
11 scientific or industrial channels. Because of the severe level of danger posed by,
12 and indeed visited upon the State and Plaintiffs' Community by, these dangerous
13 drugs, Defendants owed a high duty of care to ensure that these drugs were only
14 used for proper medical purposes. Defendants chose profit over prudence and the
15 safety of the community, and an award of punitive damages is appropriate as
16 punishment and a deterrence. Punitive damages should be awarded pursuant to the
17 common law and Cal. Civ. Code § 3294.

18 854. By engaging in the above-described wrongful conduct, Defendants
19 also engaged in willful misconduct and gross negligence and exhibited an entire
20 want of care that would raise the presumption of a conscious indifference to
21 consequences.

RELIEF

23 **WHEREFORE**, Plaintiffs respectfully pray that this Court grant the following
24 relief:

25 855. Entering Judgment in favor of The County in a final order against
26 each of the Defendants;

27 856. Declare that Defendants have created a public nuisance in violation
28 of California Civil Code Sections 3479 and 3480;

1 857. Enjoin the Defendants from performing any further acts in violation
2 of California Civil Code Sections 3479 and 3480;

3 858. Order Defendants to fund an “abatement fund” on behalf of The
4 People for the purposes of prospectively abating the ongoing opioid nuisance;

5 859. Order that Defendants compensate The County for damages to its
6 property due to the ongoing public nuisance caused by the opioid epidemic;

7 860. Awarding actual damages, treble damages, injunctive and equitable
8 relief, and forfeiture as deemed proper by the Court, and attorney fees and all
9 costs and expenses of suit pursuant to The County’s racketeering claims;

10 861. Declare that Defendants have made, disseminated as part of a plan or
11 scheme, or aided and abetted in the dissemination of false and misleading
12 statements in violation of the California False Advertising Act;

13 862. Enjoining the Defendants and their employees, officers, directors,
14 agents, successors, assignees, merged or acquired predecessors, parent or
15 controlling entities, subsidiaries, and all other persons acting in concert or
16 participation with it, from engaging in false advertising in violation of the
17 California False Advertising Act and ordering a temporary, preliminary or
18 permanent injunction;

19 863. Order Defendants to pay restitution to The People of any money
20 acquired by Defendants’ false and misleading advertising, pursuant to the
21 California False Advertising Act;

22 864. Order Defendants to pay civil penalties to The People of two
23 thousand five hundred dollars (\$2,500) for each act of false and misleading
24 advertising, pursuant to Section 17536 of the California False Advertising Act;

25 865. Awarding The County the damages caused by the opioid epidemic,
26 and their negligent misrepresentations, fraud and deceit, including (A) costs for
27 providing medical care, additional therapeutic and prescription drug purchases,
28 and other treatments for patients suffering from opioid-related addiction or

1 disease, including overdoses and deaths; (B) costs for providing treatment,
2 counseling, and rehabilitation services; (C) costs for providing treatment of infants
3 born with opioid-related medical conditions; (D) costs for providing care for
4 children whose parents suffer from opioid-related disability or incapacitation; and
5 (E) costs associated with law enforcement and public safety relating to the opioid
6 epidemic;

7 866. Enter a judgment against the Defendants requiring Defendants to pay
8 punitive damages to Plaintiffs;

9 867. Granting The County:

10 1. The cost of investigation, reasonable attorneys' fees, and all costs and
11 expenses;

12 2. Pre-judgment and post-judgment interest; and,

13 3. All other relief as provided by law and/or as the Court deems
14 appropriate and just.

15 Dated: May 8, 2018

RESPECTFULLY SUBMITTED:

16 THE PEOPLE OF THE STATE OF
17 CALIFORNIA, COUNTY OF
18 TRINITY, By Margaret E. Long,
19 OFFICE OF THE COUNTY
20 COUNSEL,
21 TRINITY COUNTY, CALIFORNIA,
22 Plaintiffs

23 Margaret E. Long (CA SBN 227176)
24 **TRINITY COUNTY COUNSEL**
25 2240 Court Street
26 Redding, CA 96001
27 Tel: 530-691-0800
28 Fax: 530-691-0700
 margaret@plelawfirm.com

29 _____
30 /s/ John P. Fiske
31 John P. Fiske (SBN 249256)
32 **BARON & BUDD, P.C.**
33 603 North Coast Highway, Suite G
34 Solana Beach, CA 92075
35 Tel.: 858-633-8337
36 jfiske@baronbudd.com

1 Peter J. Mougey
2 Archie C. Lamb, Jr.
3 **LEVIN, PAPANTONIO, THOMAS,
MITCHELL,
RAFFERTY & PROCTOR, P.A.**
4 316 S. Baylen Street, Suite 600
5 Pensacola, FL 32502-5996
6 Tel.: 850-435-7068
7 Fax: 850-436-6068
pmougey@levinlaw.com

1 Russell W. Budd
2 Laura J. Baughman (SBN 263944)
3 J. Burton LeBlanc, IV
4 S. Ann Saucer
5 Christine C. Mansour
6 **BARON & BUDD, P.C.**
7 3102 Oak Lawn Avenue, Suite 1100
Dallas, TX 75219
Tel.: 214-521-3605
Fax: 214-520-1181
rbudd@baronbudd.com
lbaughman@baronbudd.com
bleblanc@baronbudd.com
asaucer@baronbudd.com
cmansour@baronbudd.com

8
9
10
11 Michael J. Fuller, Jr.
12 Amy Quezon
13 **MCHUGH FULLER LAW GROUP,
PLLC**
14 97 Elias Whiddon Rd.
Hattiesburg, MS 39402
15 Tel.: 601-261-2220
16 Fax: 601-261-2481
mike@mchughfuller.com
amy@mchughfuller.com

17
18 Paul T. Farrell, Jr.
**GREENE, KETCHUM, FARRELL,
BAILEY & TWEEL, LLP**
419 - 11th Street (25701)/ P.O. Box
2389
Huntington, West Virginia 25724-2389
Tel.: 800-479-0053 or 304-525-9115
Fax: 304-529-3284
paul@greeneketchum.com

19 James C. Peterson
20 **HILL, PETERSON, CARPER,
BEE & DEITZLER, PLLC**
21 NorthGate Business Park
500 Tracy Way
22 Charleston, WV 25311
Tel.: 304-345-5667
Fax: 304-345-1519
jcpeterson@hpcbd.com

23 Anthony J. Majestro
POWELL & MAJESTRO, PLLC
405 Capitol Street, Suite P-1200
Charleston, WV 25301
Tel.: 304-346-2889
Fax: 304-346-2895
amajestro@powellmajestro.com

24
25
26
27
28